

PROMOTING A DECOLONIZED MODEL OF TYPE II DIABETES CARE FOR
ABORIGINAL PEOPLES LIVING ALONG THE NORTH SHORE OF LAKE HURON

By

Roger S. Pilon

A thesis submitted in partial fulfillment
of the requirement for the degree of
Doctor of Philosophy (PhD) in Rural and Northern Health

The Faculty of Graduate Studies
Laurentian University
Sudbury, Ontario, Canada

© Roger S. Pilon, 2015

THESIS DEFENCE COMMITTEE/COMITÉ DE SOUTENANCE DE THÈSE

Laurentian University/Université Laurentienne

Faculty of Graduate Studies/Faculté des études supérieures

Title of Thesis

Titre de la thèse

PROMOTING A DECOLONIZED MODEL OF TYPE II DIABETES CARE FOR
ABORIGINAL PEOPLES LIVING ALONG THE NORTH SHORE OF LAKE
HURON

Name of Candidate

Nom du candidat

Pilon, Roger

Degree

Diplôme

Doctor of Philosophy

Department/Program

Département/Programme

Rural and Northern Health

Date of Defence

Date de la soutenance October 13, 2015

APPROVED/APPROUVÉ

Thesis Examiners/Examineurs de thèse:

Dr. Monique Benoit

(Supervisor/Directeur(trice) de thèse)

(Co-supervisor/Co-directeur(trice) de thèse)

Dr. Sheila Cote-Meek

(Committee member/Membre du comité)

Dr. Marion Maar

(Committee member/Membre du comité)

Dr. Darrel Manitowabi

(Committee member/Membre du comité)

Dr. Sylvia Barton

(External Examiner/Examineur externe)

Dr. Aurélie Lacassange

(Internal Examiner/Examineur interne)

Approved for the Faculty of Graduate Studies

Approuvé pour la Faculté des études supérieures

Dr. David Lesbarrères

Monsieur David Lesbarrères

Doyen intérimaire, Faculté des études supérieures

ACCESSIBILITY CLAUSE AND PERMISSION TO USE

I, **Roger Pilon**, hereby grant to Laurentian University and/or its agents the non-exclusive license to archive and make accessible my thesis, dissertation, or project report in whole or in part in all forms of media, now or for the duration of my copyright ownership. I retain all other ownership rights to the copyright of the thesis, dissertation or project report. I also reserve the right to use in future works (such as articles or books) all or part of this thesis, dissertation, or project report. I further agree that permission for copying of this thesis in any manner, in whole or in part, for scholarly purposes may be granted by the professor or professors who supervised my thesis work or, in their absence, by the Head of the Department in which my thesis work was done. It is understood that any copying or publication or use of this thesis or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that this copy is being made available in this form by the authority of the copyright owner solely for the purpose of private study and research and may not be copied or reproduced except as permitted by the copyright laws without written authority from the copyright owner.

ABSTRACT

This thesis aims to identify and contextualize issues faced by Aboriginal peoples in the seven North Shore Tribal Council (NSTC) communities who live with type II diabetes. A constructivist grounded theory methodology, guided by a decolonizing approach to conducting research with Aboriginal peoples, was utilised in this study. Twenty two individuals living with type II diabetes participated in this qualitative study. The main research question explored the impact of colonization on the lived experience and perceptions about developing type II diabetes for Aboriginal peoples. Through the use of semi structured interviews the three main categories that emerged were *changing ways of eating, developing diabetes, and choosing your medicine*. I have developed a substantive theory that suggests that Aboriginal peoples, living with type II diabetes, often live with the perception that there is ‘no going back’ to the way things once were prior to European contact. As a result they have had to adapt the way they live with diabetes which can, at times, be at odds with Aboriginal world views. An adaptation that considers a complementary approach including both Traditional and Western ways may provide a framework for a decolonized model of type II diabetes care for Aboriginal peoples.

ACKNOWLEDGEMENTS

I would like to begin by taking this opportunity to acknowledge the many people who have provided me with their enormous support, guidance and direction without whom, this thesis could not have been possible. I would like to begin by thanking my thesis supervisor Dr. Monique Benoit. I could not possibly have selected a more dedicated, encouraging and brilliant person to help guide me through this process. Her amazing insights and endless patience were appreciated more than she will ever know. Her confidence in my ability and unfailing support will never be forgotten.

I am also very grateful to my very dedicated and encouraging thesis committee members Dr. Marion Maar, Dr. Sheila Cote-Meek, and Dr. Darrel Manitowabi. Their collective experiences and wisdom proved to be invaluable to me. I am so very appreciative of all of the time, energy and effort that they put into helping me create this work.

J'aimerais aussi saisir l'occasion pour remercier mes chères collègues à l'École des Sciences Infirmières pour leur encouragement et appui tout au long de mes études et rédaction de ma thèse.

I am also very appreciative of the continued support I have received from countless family members and friends. Their frequent encouragements and inquiries into my progress were always appreciated.

I am also very honoured and humbled that I was so readily accepted and welcomed into the communities and homes of the participants as an ally in spite of the fact that I might represent the colonizer/dominant culture for some. This demonstrated to me that in spite of all of the wrongs that have been perpetrated against Aboriginal Peoples their worldview and

beliefs about humankind have made them into a kind, accepting and dare I say most forgiving people. I want to take this opportunity to thank the communities of Atikameksheng Anishnawbek, Sagamok Anishnawbek, Serpent River First Nation, Mississauga First Nation, Thessalon First Nation, Garden River First Nation and Batchewana First Nation for allowing me the privilege of coming into their communities to hear from them.

Finally and perhaps most importantly I want to thank my incredible wife Jody who has stood by me over the last eighteen years and provided me with amazing support and unconditional love. I realize the many sacrifices that she willingly endured as a result of my journey and for that I will be eternally grateful. She has and will always remain my biggest fan, encourager and best friend. I love her more than words could ever express.

Chi Meegwich-Merci-Thank you

I am dedicating my work in the loving memory of my mother Adeline who sadly passed away before she was able to see this thesis completed.

This work is also dedicated to all of the community members who invited me in to their homes and shared their stories with me as well as to each of the seven First Nation communities along the North Shore of Lake Huron.

TABLE OF CONTENTS

Abstract	iii
Acknowledgements	iv
Dedication	vi
Table of contents	vii
Introduction	xi
Aboriginal Peoples and diabetes	xiii
Terminology	xv
Statement of the problem	xx
The aim of the research	xxii
Research question	xxiii
Description of the population	xxiv
Originality of this research	xxvii
Chapter Overview	xxvii
Chapter One: Review of the literature	1
Conducting the review	1
Scope of the review	3
1.1 History of Diabetes in Aboriginal peoples	4
1.1.1 Health status of Aboriginal peoples	7
1.1.2 The extent of type II diabetes in Aboriginal peoples	9
1.2 The biomedical model of diabetes	11
1.2.1 Theories of causation of diabetes in Aboriginal peoples	13
1.3 Sociopolitical Dimension of Diabetes	18
1.3.1 Canadian health policy impact on Aboriginal health	19
1.3.2 Policy influence on ways of eating	23
1.3.3 Canadian health policy limitations related to diabetes care in Aboriginal peoples	24
1.4 Empirical perspective	27
1.5 Research focussing decolonization	29
1.6 Gaps in the literature	33
Chapter Two: Theoretical and conceptual frameworks	36
2.1 Qualitative studies using a Constructivist approach	37
2.2 Epistemological perspective of knowledge	38
2.3 Colonization	41
2.3.1 James Collier's theory	41
2.3.2 Defining colonization	42
2.3.2.1 Frantz Fanon	43
2.3.2.2 Albert Memmi	44
2.3.2.3 Edward W. Said	44

2.3.2.4	Taiaieke Alfred	46
2.3.2.5	Glen Sean Coulthard	48
2.3.2.6	Linda Tuhiwai Smith	50
2.3.3	The Eurocentric and imperialist version of history	51
2.3.3.1	Critics of the establishment of reserves	53
2.3.3.2	The colonizer and the colonized	55
2.3.3.3	The political perspective of being colonized	58
2.4	Theoretical Framework	60
2.4.1	Postcolonial theory	60
2.4.2	Critiques and limitations of postcolonial theory	63
2.5	Conceptual Framework:	67
2.5.1	Culture	68
2.5.2	Cultural safety	72
2.5.3	Health	74
2.5.4	Self-determination	76
2.5.5	Decolonization	78
2.5.5.1	Practice of decolonization in order for health	82
2.6	Summary	84
Chapter Three: Methodological perspective		86
3.1	Decolonizing the methodology	86
3.2	Qualitative research	90
3.3.	Grounded theory	90
3.3.1	Constructivist grounded theory	91
3.4	Researcher reflexivity	92
3.5	Ethical considerations	96
3.6	Recruitment and data collection procedures	97
3.6.1	Recruitment of the participants	97
3.6.2	Participant profiles	99
3.6.3	Data collection procedures	101
3.6.4	Theoretical sampling	104
3.7	Data management and analysis	104
3.7.1	Overview of analysis process	105
3.7.2	Theorizing in grounded theory	108
3.8	Summary	112
Chapter Four: Changing ways of eating		113
4.1	Being connected to the culture and land	114
4.1.1	Giving meaning to the culture	115
4.1.2	Living off the land	118
4.1.3	Traditional foods	122
4.2	Disconnecting from the culture and land	128
4.2.1	Rejecting “traditional foods”	132
4.2.2	Depending on “western foods”	137

4.2.3	No going back	145
4.3	Summary	148
CHAPTER FIVE: Developing diabetes		150
5.1	Inevitable outcome	152
5.1.1	Genetics and culture	153
5.1.2	Lifestyle changes	159
5.2	Linking changing ways of eating with illness	162
5.2.1	Traditional ways	163
5.2.2	Western ways	165
5.3	Summary	172
CHAPTER SIX: Choosing your medicine		173
6.1	Traditional medicine	174
6.1.1	Meaning of traditional medicine	175
6.1.2	Hidden practice	182
6.1.3	Limitations of Traditional medicine	184
6.2	Western Medicine	191
6.2.1	How it came to be	192
6.2.2	Doing what you are told	196
6.3	Combining traditional and western ways	200
6.3.1	Complimentary	200
6.3.2	They don't mix	203
6.4	Summary	205
CHAPTER SEVEN: Discussion		206
7.1	The impact of colonization on type II diabetes: presenting the Substantive theory	206
7.2	Colonization's impact on health and eating	209
7.3	Developing diabetes	220
7.4	Diabetes care	226
7.5	Decolonizing the diabetes experience	238
7.6	Summary	245
CONCLUSION		247
Achievement of the study's aims and objectives		247
Implications for research and practice		248
Limitations of the study		250
Recommendations		252
GLOSSARY		257
REFERENCES		259

APPENDICES

Appendix A-North Shore Tribal Council Approval	293
Appendix B –LU-REB Approval	295
Appendix C-LU-REB change request	297
Appendix D-LU-REB change approval	298
Appendix E-Information for participants	299
Appendix F-Consent form	302
Appendix G-Demographic data	303
Appendix H-Interview guide	304
Appendix I-Participant demographics	305
Appendix J (Sample interview summary)	307
 Table 1: Participant profiles	 100
 Figure 1: Proposed model for a decolonized approach to Type II Diabetes care for Aboriginal peoples	 244

INTRODUCTION

I have worked as a Nurse Practitioner (NP) in primary health care for over 20 years. During that time I spent several years providing primary health care to Aboriginal peoples living in both remote isolated and rural First Nation communities in Ontario. It was during this period of time that I encountered a significant number of individuals living with type II diabetes.

Over the course of my career I have come to realize that a one size fits all approach to diabetes care does not seem to be very effective and even appropriate when it comes to Aboriginal peoples. I have frequently observed various health care providers deliver what I consider to be paternalistic and culturally unsafe approaches to diabetes care provided to this population. For the purposes of this discussion this concept is intended to ultimately consider and address complex power relationships that can exist between Aboriginal peoples and health care providers. For example many health care providers that I observed often expect their patients to do what they are told and not to ask questions. This fosters a notion of being scolded when one is not following instructions and even a fear of being judged. In addition this type of approach can also promote forced compliance under the fear that services may not continue. For a population who has long been marginalized and oppressed in so many ways as a result of being colonized by the settlers, feelings of disempowerment and fear of authority within a health care context have developed. As a health professional I find that reality troubling and unacceptable and at odds with an approach to health care that is culturally safe.

As I delved into the Aboriginal diabetes literature I soon realized that the majority of the research conducted to date has been pre occupied with what I would consider to be more of

the bio medical perspectives of this disease and less of the social, cultural, or political aspects of diabetes. There appears to be a paucity of research that has examined the particular impact of colonization on the lived experience of type II diabetes for Aboriginal people from an interdisciplinary perspective. Researchers are also only beginning to explore and understand how a narrowly focused predominant western and biomedical approach to managing diabetes might impact Aboriginal people. The limitation of this longstanding approach to illness prevention and disease management, which is firmly rooted in a positivist paradigm, fails to consider the relationships between social determinants of health (SDOH) such as oppression and health status. Ultimately there is a need for expanded ways of addressing health and illness (Smye & Browne, 2002; Iwasaki, Bartlett, & O'Neil, 2004).

During my clinical career I often found myself asking how we, as health care providers, can do a better job in the area of diabetes care for Aboriginal peoples. I realized that in order to answer this and many other questions that I would need to explore this phenomenon in a more formal and systematic manner. At the time I was also beginning to appreciate the need and importance for conducting research in order to be able to answer questions that did not seem to have any answers yet.

I came to realize that what was needed was an approach that expanded beyond a traditional clinical biomedical one that often excludes social, cultural, psychological and behavioural dimensions of illness and that I would need to consider the complexity of the issue from a more pragmatic grass roots perspective. I also came to recognize that quite often the impact of colonization was missing from much of the discourse surrounding diabetes in Aboriginal people. Although my conceptualization of colonization has grown exponentially

since I began this journey I must readily admit that as a non-Aboriginal white male who may represent those who are dominant and oppressive, I will likely never be able to fully comprehend the extent to which colonization has and continues to impact Aboriginal peoples in Canada. Ultimately an important question that emerged was how colonization impacts Aboriginal people who live with diabetes and how the colonized experience is represented and conceptualized by those who experience it.

Aboriginal peoples and Type II Diabetes

Diabetes is most commonly considered and conceptualized from a biomedical perspective (Ferreira & Lang, 2006) and much less so from a social, political, and cultural perspective. This view can be especially limiting for Aboriginal peoples. There are many notions and theories with respect to how individuals develop diabetes. Consequently it must also be considered from a social, political and cultural perspective (Joe & Young, 1998). It is with this view in mind that I have chosen to position myself as I embarked on my journey to better understand to what extent colonization has impacted the way in which Aboriginal peoples in Canada, but more specifically how those along the North Shore of Lake Huron, are living with type II diabetes.

Much of the extant research in this area has focused on the relationship between the endocrine and digestive systems at the expense of neglecting how an individual's nervous system may also play a role in the development of this disease. More specifically there is more and more evidence to suggest that chronic exposure to stress and past trauma may also contribute to the onset of diabetes (Poudrier, 2007; Joe & Young, 1994). It has been well documented in the literature that Aboriginal peoples have indeed experienced trauma and stress

as a result of European contact and continue to do so today (Poudrier, 2007; Ferreira & Lang, 2006; Smith, 1999; Joe & Young, 1994).

For Aboriginal peoples diabetes is often referred to as a disease of modernization. The current understandings of diabetes which are mostly biomedical in nature are limited and do not address other important factors such as racism, marginalization, inequality, disparity and violence. Given that there is overwhelming evidence that such events are ongoing for Aboriginal peoples today these factors should be given particular attention when attempting to understand what it is like to be an Aboriginal person living with type II diabetes in our contemporary society. As such there needs to be a “radical redefinition of what diabetes is and what it represents for Aboriginal people” (Ferreira & Lang, 2006: 8). One way to advance the discourse with respect to diabetes in Aboriginal peoples is to consider a decolonizing approach not only in how it is defined and understood but also in how it is addressed. It is therefore important to further explore what is understood by the concept of decolonization.

It appears that type II diabetes rates are even higher in Aboriginal people who live in First Nation communities (i.e reserves) compared to all other Aboriginal people (CDA, 2013; Ferreira & Lang, 2006; Rock, 2003; Shubair & Tobin; Health Canada, 2000). In terms of social classes there is often a link made between living conditions for Aboriginal people with type II diabetes and decreased income, education, and poorly developed human and social capital especially in Aboriginal people who live in more remote or isolated regions (Smye & Browne, 2002). Finally in terms of gender there appears to be a link between gestational diabetes in Aboriginal women and the development of obesity in their children. This correlation which can be viewed as a social issue eventually manifests itself into higher rates of type II diabetes for

Aboriginal people compared to the general population (CDA, 2013; Dyck et al., 2010; Shubair & Tobin, 2010; Gahagan & Silverstein, 2003; Young, Reading, Elias & O'Neil, 2000).

TERMINOLOGY

I felt it important to develop a section that speaks about terminology because in the literature and at times during normal discourse one encounters many terms in reference to Aboriginal peoples. These different terms can often come with different understandings and meanings. In order to further assist with terminology that will be commonly encountered in this thesis a *Glossary* of some of the most important and frequently recurring terms and concepts can be found at the end of this thesis. The various terms used to describe Aboriginal peoples can also be found in the glossary.

Aboriginal peoples

Throughout this thesis the term Aboriginal and/or Aboriginal peoples will be, as much as possible, used exclusively. The term is considered to be inclusive and most commonly used in a Canadian context. That being said some have argued that the term Aboriginal is a legally defined term by the Constitution which was imposed by the government “referring to all of indigenous peoples of Canada and their descendants” (Allen and Smylie, 2015, ii). In spite of this I have elected to use the term Aboriginal throughout this thesis. This is a conscious decision which I have based in part on my understanding and respect for Aboriginal peoples culture as well as a result of its relatively consistent use in Canadian literature. I have also taken this position because there are many terms that one might encounter in the literature as well as throughout the course of casual conversation when referring to Aboriginal peoples. Along the North Shore terms such as First Nation citizens, First Nations peoples, and community members are often

encountered when interacting with the various community based partners and key stakeholders throughout this research project.

For example, one might encounter the terms Indian, Aboriginal, First Nations Indigenous, Anishnaabe, Native, Métis, Eskimo and Inuit. Some of these terms or labels can be seen as being racist and even leading to the formation of stereotypes. It is important to understand what these terms mean as well as their origins and when and if it is ever appropriate to use them. As Warry (2007) and many others before him have contended, it all depends on how these terms are used and by whom.

The term Anishnaabe is often used amongst Aboriginal peoples who live around the Great Lakes as a form of self-identification and means First or Original peoples (Spielmann, 2009). This particular term tends to be primarily used by Aboriginal peoples themselves and less so by others. I have encountered this term being used on a number of occasions particularly amongst community members during my time spent in the North Shore Tribal council communities. It was used by different individuals in different contexts without any regular consistency.

Apart from coming across the term status Indian in constitutional or official government policy the term 'Indian' is rarely if ever used anymore especially in mainstream society as it has negative connotations and is often found offensive by Aboriginal peoples, particularly when used by non-Aboriginal people.. With this in mind it strikes me as quite inappropriate that the term Indian continues today to be found in key pieces of legislation and law and even at times in the media. As Warry has suggested "the use of the word Indian in media reports commonly signals a right-of-centre political orientation" (Warry, 2007: 9). This term is also racially loaded in that it originates back to the times of first contact between Europeans and

Aboriginal peoples when it had been believed that the settlers had arrived in India. It is no accident that it has remained as part of the discourse or even in important policy or legislation. The derogatory and racist insinuation of the term 'Indian' has and continues today to establish a hierarchy between Aboriginal and non-Aboriginal peoples since it was inaccurately used from the outset and has come to symbolize a more stereotypical and less politically or even culturally correct view of Aboriginal peoples. Over the course of conducting my interviews it was not unusual for some of the participants themselves to use the term "Indian" in reference to the people or as a descriptor such as when referring to food or activities or ways of doing things. Similarly the term native, although perhaps seen as less racist by some, is rarely used anymore for many of the reasons just cited.

Another term that can be encountered is First Nations or First peoples. This term came into common usage in the 1970s to replace the word "Indian," which some people found offensive (Dickason, 2002). Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Aboriginal peoples in Canada, both Status and non-Status. Some Aboriginal peoples have also adopted the term "First Nation" to replace the word "band" in the name of their community (Government of Canada, 2012). Cairns (2001) points out that one of the goals of this term is "establishing historical priority, from which positive consequences are expected to follow" (32). This term is viewed contentious by conservative and assimilationist scholars, as evidenced by Flanagan's (2012) rejection of the notion that Aboriginal peoples were the original inhabitants and suggests that they are part of the "first series of immigrant populations" to become established in Canada (43). The term is politically loaded and appears to make some, especially those who share neo-conservative views,

uncomfortable because it is viewed as more empowering. This term will be encountered frequently throughout this thesis and as a result I felt it important to provide the reader with some background information on its origins.

The term Indigenous tends to be used in a broader and often international context and refers to the original inhabitants of a land, that is, those who were living there prior to the arrival of outsiders or settlers. Unlike the terms Indian or native it does not appear to have the same negative connotation. The United Nations (1983) has described Indigenous peoples as pre-invasion and pre-colonial societies. Therefore the term may also occasionally be encountered throughout this thesis especially when referring to international literature.

In Canada the term “Aboriginal” refers to individuals who identify with at least one Aboriginal group, like First Nation (Indian), Métis or Inuit (Eskimo), and/or those who report being a Treaty Indian or a Registered Indian as defined by the Indian Act of Canada and/or who are members of an Indian Band or First Nation (Frideres & Gadacz, 2008; Statistics Canada, 2008; Brant-Castellano, 2004; Health Canada, 2000). This is perhaps the most widely used and accepted term, at least in contemporary times, when referring to Canada’s First Peoples. I would suggest that the term Aboriginal is also more inclusive.

There exists much cultural diversity amongst Aboriginal groups which could be attributable to “varying colonial histories among the villages” (Jacklin, 2009: 980). This certainly was evident in that each of the seven First Nation communities along the North Shore of Lake Huron possessed distinct characteristics and qualities unique in each community. Poonwassie and Charter (2001) assert “developing an in-depth understanding and respect for the values, beliefs and practices of Aboriginal peoples in a specific geographical area are vital to supportive healing

practices” (Poonwassie & Charter , 2001: 66). This can translate into different experiences for each of these groups as they pertain to health. The use of ‘peoples’ in the plural form is therefore important since it recognizes the fact that there are many distinct Aboriginal cultures in Canada (Warry, 2007). Heintze (1993) further adds that when the word ‘Peoples’ is capitalized it suggests a right to self-determination with regards to economic, social and cultural affairs. It is interesting to note that the impact of colonization has and continues to play an important role in what term is utilized when describing Aboriginal peoples and by whom the term is employed. It is for this reason that the terminology that is employed in describing Aboriginal peoples is important to consider and a part of the conceptual framework.

Certain terminology can at times be viewed as racist for some and inappropriate for others (Warry, 2007). From the terms Aboriginal, Native and Indian to being diabetic to living with diabetes, all of these words can and do have meanings that at times can be seen as negative or perhaps even derogatory. Colonialism, which has direct ties and influence on how terms are defined, utilized and perhaps even understood, has had far reaching impact on Aboriginal peoples around the world. This impact has extended beyond the meaning of words to affecting various dimensions.

Language isn’t neutral and as Warry (2007) pointed out

“Words often have power. They are frequently laden in judgment and stigma. A writer’s choice of words indicates political orientation and potential bias. The era of political correctness may be gone, but we have been left with the awareness that we should strive for language that is non-offensive and accurate” (Warry, 2007: 9).

One of the ways that this can be accomplished is by continuously striving to consider important terms and concepts beyond the traditionally accepted and understood Western view to include the Aboriginal perspective. For the purposes of this thesis I have chosen to employ the term Aboriginal peoples in a fairly consistent manner. The term Aboriginal itself is not without its critics (Alfred, 2009). That being said the reader will at times encounter different terms that are used by various authors and the participants themselves such as First Nations, native, status, and on occasion Anishnaabe. Other Indigenous terms such as Anishnaabe or Anishnawbe may also be employed and serve as an indication of practicing a culturally safe and decolonizing form of representation. Definitions of each of these terms have been provided in the glossary.

STATEMENT OF THE PROBLEM

Type II diabetes is a complex and multifaceted chronic illness that is often difficult to manage (CDA, 2013; Ferreira and Lang, 2006; Joe & Young, 1994). Type II diabetes accounts for 90% of all cases of diabetes and is frequently associated with potentially life threatening complications (Pilkington, Daiski, Bryant, Dinca-Panaitescu, Dinca-Panaitescu, & Raphael, 2010; Pilkington, Daiski, Lines, Bryant, Raphael, Dinca-Panaitescu, & Dinca-Panaitescu, 2011). There is a higher incidence of type II diabetes in certain ethnic groups including Aboriginal peoples (CDA, 2013; Wilson & Young, 2008). Diabetes has reached “epidemic proportions among Aboriginal peoples in Canada, with national age-adjusted prevalence 3 to 5 times higher than that of the general population and as high as 26% in individual communities.” (CDA, 2013, p. S191; Rock, 2003; First Nations and Inuit Regional Health Survey [FNIRHS] 2002).

The majority of cases of type II diabetes tend to occur in adults. However, over the last decade, this disease has become more common in children and adolescents especially those of Aboriginal decent (Canadian Diabetes Association [CDA], 2013; Young, Reading, Elias & O'Neil, 2000; Shubair& Tobin, 2010). It is evident in reviewing the literature that the scope of the problem of type II diabetes is a significant one especially for Aboriginal people who are disproportionately affected (Ferreira & Lang, 2006). A more detailed exploration and review of the literature with respect to colonization and the historic, political, social and biomedical dimensions of diabetes in Aboriginal peoples are presented in Chapter one.

In spite of the increasing prevalence of diabetes especially in Aboriginal peoples, the chapter dedicated to diabetes in Aboriginal peoples is placed almost at the very end of the CDA guidelines. This represents for me another example of marginalization. It is also important to make mention of the fact that, although the authors acknowledge that Aboriginal peoples have different ways of understanding and experiencing health and illness, there is never any explicit mention of the impact of European contact or colonialism nor is there mention of the notion of cultural safety in the guideline itself (CDA, 2013). This omission seems to fail to take into account the importance of Aboriginal peoples' experiences as it relates to diabetes care.

It is my contention that Aboriginal people's experience has been significantly impacted by the historical and ongoing legacies of colonialism (Kelm, 1998; Battiste, 2000; Cote-Meek, 2010). This has occurred in a variety of ways but perhaps another example was when children were forcibly taken away not only from their families but from their cultures and ways of life and made to adapt to foreign ways in Indian Residential Schools (Kaspar, 2014; Mosby, 2013; Ross, 2014; TRC, 2012, 2015). Although there are numerous ways in which Aboriginal peoples

have had to adapt, their access to the land and the foods that they eat was particularly influenced. In many cases children in residential schools went from eating traditional foods such as wild game, fish and naturally occurring plants and other foods to consuming a diet which often consisted of foods that they had never been exposed to and was essentially foreign to them (Ross, 2014) . The imposition of rations as well as the increased cost associated with healthy foods also contributed in a significant way to the increased burden of diabetes amongst Aboriginal peoples (Kelm, 1998). These drastic changes in lifestyle such as living off the land and ways of eating have often been linked to the increasing burden of chronic illnesses such as type II diabetes in Aboriginal peoples (Battiste, 2000; Joe & Young, 1994; Ross, 2014; Waldram, Herring, & Young, 2007; Waziyatawin-Wilson, A., & Yellow Bird, M., 2005; Waziyatawin & Yellow Bird, M., 2012).

The objective of my research was to better understand Aboriginal peoples' experience of living with type II diabetes and their perceptions about how the illness develops. The information gained from the research could perhaps serve to improve the cultural safety of diabetes care provided in Aboriginal communities. In spite of an increasing number of qualitative studies the impact of colonization on the development and management of diabetes is still poorly understood.

THE AIM OF THE RESEARCH

This thesis has been developed using an interdisciplinary approach to health. This required an exploration of the complex relationship between type II diabetes as a disease (biomedical aspects) in relation to Aboriginal culture (in the anthropological and political framework) and colonization (in a social and historical context) in a norther and rural setting

(geographical context). The interdisciplinary aspects of the thesis are therefore concerned with biomedical, geopolitical, sociological and anthropological issues that might impact the health of Aboriginal peoples. I was not influenced by one more than the other since I wanted to approach my topic from a broad and truly interdisciplinary perspective. Secondly, this thesis also aimed to identify and contextualize specific issues faced by Aboriginal peoples in North Shore Tribal Communities who live with type II diabetes and to develop a substantive grounded theory that might explain their experiences which in turn can assist in the development of a decolonized model of diabetes care for this population.

RESEARCH QUESTION

A qualitative approach is required when a researcher works with complex unstructured data in order to attempt to gain new understandings of a phenomenon (Creswell, 2003; Creswell, 2007). The initial question being asked will also guide the researcher to select a qualitative paradigm. Creswell (2007) recommends starting with as broad a question as possible often referred to as a “grand tour” question that tends to state the phenomena to be studied in a very general way (108). The formulation of this type of question provides the researcher with flexibility in order to explore the phenomenon of interest more freely (Corbin & Strauss, 2008; Charmaz, 2006). The way in which the question is asked will further assist the researcher in determining which qualitative methodology is likely most appropriate. Questions that appear to focus on a process tend to be associated with grounded theory (Creswell, 2007).

The central research question that this study explored was:

What is the impact of colonization on the lived experience and perceptions about developing type II diabetes for Aboriginal peoples living along the North Shore of Lake Huron?

In addition to the central research question the following related questions which included cultural aspects of Aboriginal life were considered in order to help explain perceptions about the development of type II diabetes which included: What role does traditional culture play in the experience of living with type II diabetes? How and why do the participants select between Western and Traditional forms of medicine? These two more focused questions assisted me in identifying the multiple realities of the various participants who contributed to this study. By exploring these questions I was able to meet the aims of the study which were addressed in the preceding section.

DESCRIPTION OF THE POPULATION

The primary area of interest for this question consists of the geographical area between the city of Greater Sudbury and Sault Ste. Marie Ontario. The distance between these two cities is approximately 300 km. According to the 2011 Census there were an estimated 3725 people living in the North Shore First Nation communities. Since the focus will be on Aboriginal peoples living in First Nations communities along the North Shore of Lake Huron, North Shore Tribal Council communities were of particular interest.

There are seven First Nation communities in this tribal council and they include from east to west: Atikameksheng Anishnawbek (Whitefish Lake), Sagamok Anishnawbek, Serpent River First Nation, Mississauga First Nation, Thessalon First Nation, Garden River First Nation, and Batchewana First Nation. Approximately 40% of all registered members of

each of these communities were said to be living in their respective First Nations (Statistics Canada, 2011). All First Nations are located along the North Shore of Lake Huron within the Robinson-Huron Treaty area. This treaty was signed in 1850. The original intent of this and many others like it across Canada was to forge an agreement between Canada's First peoples and European settlers that was based on the premise of respect and sharing when it comes to the land and resources however as Alfred (2009) contends this has not been the case. Treaties throughout Canada remain highly contested and a source of a conflict between Aboriginal peoples and the Canadian government (Alfred, 2009; Warry, 2006). These communities were selected because of their rural context, their association with the North Shore Tribal Council (NSTC) and because they are populated by Aboriginal peoples.

In the 2010 annual report of the North Shore Tribal Council the N'Mninoeyaa Community Health Access Centre program indicated that type II diabetes was the number one reason for seeking care in both 2009 and 2010 from one of the program's Regulated Health Professionals (physicians, nurse practitioners, and dietitians). The N'Mninoeyaa Community Health Access Centre, in partnership with local First Nation health staff, provides primary health care services in each of the 7 First Nation communities along the North Shore of Lake Huron as well as to the Indian Friendship centre in Sault Ste Marie (Mamaweswen, 2010). Given the high prevalence of diabetes in these communities a new program called "Naadmaadsaan" (helping one's self) was launched in January 2010. This program which is funded through the Northern Diabetes Health Network (NDHN) has a mandate to prevent diabetes related complications through assessments and follow up and by delivering various forms of education, counseling, and support services. It is important to note that the Ministry of

Health and Long Term Care in Ontario ended the funding for the NDHN in November 2012. This network had a mandate to deliver access to diabetes services and education programs in communities across Northern Ontario. The funding for diabetes services and education program was subsequently transferred to the Local Health Integration Networks (LHIN) in the north.

This population was selected for two reasons. First the researcher had experience in providing primary health care services in several of the communities along the North Shore of Lake Huron. This experience, along with the establishment of a positive and trusting working relationship within and throughout the communities, made it possible to gain access to the community members in order to further explore this phenomenon. Second, in exploring the question of the impact of colonization on the health of Aboriginal people and on diabetes, in particular, there is very little known beyond the fact that diabetes has reached epidemic proportions amongst Aboriginal peoples and is linked to lifestyle changes, obesity, and changes in dietary practices.

Ultimately I hope to influence practice with respect to type II diabetes care in Aboriginal peoples in the participating communities and perhaps even beyond. This can be accomplished using a culturally safe and decolonized model of care that will be based and influenced by the emerging theory from this work. I believe that health care providers need to become more aware of the significance of colonization with respect to type II diabetes in Aboriginal peoples and the need for a decolonized approach.

ORIGINALITY OF THIS RESEARCH

No one in my field of primary health care appears to have looked exclusively at promoting a decolonized model of diabetes health care delivery for Aboriginal people. Some authors, researchers, academics have discussed the theoretical impact of colonialism and imperialism on Aboriginal peoples. However I will demonstrate in this thesis how a group of Aboriginal peoples living with type II diabetes have been and continue to be negatively impacted by colonial approaches and policies especially when it comes to diabetes care with the goal to promote a decolonized model of diabetes care.

I will further argue that, based on my experience and observations, many health care providers who interact with Aboriginal peoples do not demonstrate a good understanding of the culture and the historical and ongoing impacts of colonization that plague them. In fact, as supported by Warry (2007) the notion of colonization is rarely if ever considered by the majority of health care providers with whom I have interacted over the years. This also seems to be the case in much of the literature that has explored type II diabetes in Aboriginal peoples. I believe this is problematic given the implications of colonization. I also believe that the experience of living with type II diabetes for Aboriginal peoples can only be fully understood if the historical and ongoing impacts of colonization are considered

CHAPTER OVERVIEW

The remainder of the thesis is divided into seven chapters. In the first chapter, I present the review of the literature. I pay particular attention to the history of diabetes especially as it relates to Aboriginal peoples who are central to this study. I also explore and critique the

predominantly biomedical model of care, lifestyle issues, as well as the impact and limitations of Canadian health policies with respect to diabetes care for Aboriginal peoples.

In Chapter Two I describe the theoretical underpinnings for the study that was established to guide the process and in large part informed by my extensive review of the literature. I will also present my conceptual framework which essentially consists of a critique of the biomedical approach to diabetes care in favor of a reformulation of the biomedical model that takes into consideration colonialism.

In Chapter Three I provide an overview of the research methodology. I then present the research question as well as provide a description of the population, sampling procedures, data collection and finally data analysis.

In Chapters Four, Five and Six I present the findings related to the three main categories that emerged. Chapter Four presents the first main category of changing ways of eating and the associated dimensions of being connected to the land and culture and disconnecting from the culture and land. In Chapter Five the second main category named developing diabetes and the associated dimensions of inevitable outcome and linking changing ways of eating with illness is presented. In Chapter Six the findings related to the third main category which was named choosing your medicine and the associated dimensions of Traditional medicine, Western medicine, and combining Traditional and Western medicine are presented.

In Chapter Seven I introduce the substantive theory that was developed as a result of the interaction between the three main categories presented in Chapters Four, Five and Six. I then provide a discussion of the key findings of the study and the link between these findings

and the literature that was reviewed. I end with the conclusion that will provide my final thoughts, identify the study strengths and limitations, and provide recommendations followed by closing remarks.

CHAPTER ONE:

REVIEW OF THE LITERATURE

The following review of the literature provides a critical review of the theoretical and empirical literature related to colonization and type II diabetes in Aboriginal Peoples.

The research question has helped to guide this particular review of the literature. As previously stated colonization has impacted Aboriginal peoples in many ways and this likely includes the way in which they view and experience type II diabetes. The research question being asked is: What is the impact of colonization on the lived experience and perceptions about developing type II diabetes for Aboriginal peoples living along the North Shore of Lake Huron? In order to address this question the historical, biomedical, and socio-political dimensions of diabetes care for Aboriginal peoples will be further explored.

Explanations of diabetes and how it is managed will also be considered. Particular emphasis will be placed on the nutritional aspects as well as health care practices related to diabetes care in Aboriginal peoples. These dimensions will serve as a framework that will help to inform and shed light on what is presently known about the impact of colonization of Aboriginal peoples in Canada and their experience of living with diabetes.

Once the groundwork has been established, a review of selected empirical works will be presented. The aim will be to present the body of work that currently exists that has considered the central question of this thesis in a direct or perhaps even indirect manner.

CONDUCTING THE REVIEW

The issue of when to carry out the review of the literature when conducting grounded theory research has been extensively debated and remains contentious especially amongst the

classic grounded theorists (Charmaz, 2006; Corbin & Strauss, 2008; Glaser, 1978). It has been suggested that the review of the literature should only take place once the analysis has been completed in order to ensure that the research remain as objective as possible and not be influenced or ‘contaminated’ (Glaser, 1978) by existing ideas or theories (Charmaz, 2006). Some have argued that this is unrealistic since most researchers do not enter the field as a ‘tabula rasa’ or blank slate but rather bring with them knowledge and experience (Corbin & Strauss, 2008, 26). This is why the researcher’s positioning and reflexivity are such important elements to consider when conducting grounded theory research. It provides the researcher with an opportunity to declare potential biases and influences that they bring to the phenomenon under study. I certainly brought my own biases and assumptions into this study and will attempt to declare these whenever possible.

Although an extensive review of the literature will be presented in Chapter One it is important to point out that this review was not conducted at the outset but rather throughout the course of data collection and analysis. An initial preliminary review was conducted in order to fulfil the requirements of submitting a research proposal as part of comprehensive examination as well as to complete the ethics approval process. It is also expected that a doctoral thesis will provide a significant original contribution to knowledge in an area where there appears to be a gap. In order to confirm this, a preliminary review of the literature was conducted and I was able to determine that a dearth of knowledge did in fact exist which helped to provide a rationale for this study.

I elected to delve more deeply into the literature throughout the data collection phase and as the analysis progressed. This approach allowed me to turn to the literature during the

analysis in order to support some of the findings as they emerged and it also helped me to contextualize the findings of the study in light of existing knowledge as Strauss and Corbin suggest (2008). The movement between data collection, analysis and review of the literature are components of the constant comparative method of analysis which will be addressed in greater detail in the methodology chapter. Literature from this review will be revisited and woven into the discussion chapter in order to help integrate it with the findings of this study and provide context for the substantive theory that emerged (Charmaz, 2006).

SCOPE OF THE REVIEW

The review of literature on type II diabetes in Aboriginal peoples included theoretical and empirical works. It was developed using a systematic approach with various sources being consulted such as books, government reports and peer reviewed journals. A number of databases including MEDLINE, PUBMED, PROQUEST, Google Scholar and CINAHL were searched by combining keywords such as type II diabetes, Aboriginal, Indigenous, policy, colonization, decolonization, epidemiology, etiology and research. The time period for this review included post World War II publications since the prevalence of diabetes among Aboriginal peoples did not seem to manifest itself prior to WW II and up to the time that the manuscript was written in 2015.

Research related to type II diabetes in Aboriginal people has been conducted extensively throughout the world (Ferreira & Lang, 2006; Jo & Young, 1994; Waldram et al., 2007). Although the international literature from Australia and New Zealand in particular was considered it will not form part of the scope of this review. The emphasis of the review was on North American, particularly the Canadian literature in the exploration of type II diabetes in

Aboriginal people. The review also focused on literature that included and considered the impact of colonization and utilized participatory approaches, Indigenous methodologies, and considered the notion of decolonization either directly or indirectly. The search strategy also included the removal of non-relevant works, in particular, literature that did not focus specifically on Aboriginal peoples with type II diabetes.

For the most part and whenever possible an emphasis was also placed on work that focused on Aboriginal peoples living on reserve. This was deliberate for two reasons. Firstly the study in question focused on Aboriginal participants living in First Nation communities along the North Shore of Lake Huron. Secondly, there tend to be differences in the needs and experiences of Aboriginal peoples living off-reserve or in more urban centres (Ferreira & Lang, 2006). The review did not include works that had been done with Métis or Inuit populations or groups. Ultimately it is possible that some articles that have been published in journals or found in databases that were not explored may exist and were not considered in this review of the literature. Every attempt was made to be as inclusive and thorough as possible.

The following section will begin by exploring the history of diabetes and extent of the problem in Aboriginal peoples. This will be followed by a critical discussion of the biomedical western model of diabetes care in the Aboriginal population. Finally I will address the socio-political dimension by exploring the impact and limitations of Canadian health policy on Aboriginal peoples and their health particularly as it relates to type II diabetes.

1.1 HISTORY OF DIABETES IN ABORIGINAL PEOPLES

Diabetes is an old disease that is known to date as far back as the first century and was discovered by the Greeks (CDA, 2013; Medvei, 1993; Poretsky, 2009). In spite of its

longstanding history it was not until the beginning of the 20th century that scientists gained an understanding of the pathogenesis at least of this disease and treatment with the discovery of insulin by two famous Canadians Banting and Best in the 1920s (CDA, 2013). Clearly the emphasis in diabetes research in the early years was on the biomedical perspective of the illness.

Prior to 1940, diabetes is believed to have been essentially nonexistent in Aboriginal people (Ferreira & Lang, 2006; Hernandez, Antone & Cornelius, 1999; Joe & Young, 1994; ; Rock, 2003; Waldram et al., 2007). A significant increase in the disease appeared to emerge after the Second World War (Ferreira & Lang, 2006; Joe & Young, 1993; Kelm, 1998; Young, 1994; Waldram, Herring, & Young, 2007). Young (1994) has suggested that the reason for this emergence may be attributed to the fact that prior to this data had not been collected in any significant way and that it was at that point in time that Aboriginal people underwent the most significant changes in their ways of living. Access to health care was then and continues today to be a factor that can also be considered to impact the actual rates and outcomes related to type II diabetes. It is interesting to note however that in spite of the fact that diabetes has been around for centuries in other populations its high incidence amongst Aboriginal people was relatively unknown prior to World War II, hundreds of years following the devastating impact of colonization from European contact which resulted in the imposition of the Indian Act, the reserve system, and Indian Residential schools to name a few (Kelm, 1998).

Prior to European contact there existed little if any of the diseases that plagued Europeans amongst Aboriginal people such as small pox, cholera, and measles to name a few (Waldram et al., 2007). Campbell (1989) contends that Aboriginal people experienced a drastic

alteration in their health status due to European hegemony. These changes included but are not limited to such examples as government engagement in biological warfare with small pox infested blankets as well as the establishment of the reserve system which limited traditional foods and exchanged low calorie highly nutritious food with higher calorie and less nutrient foods (Kelm, 1998; Waldram, Herring, & Young, 2007). Others believe that the centuries of oppression have led to the emergence of and significant increase in chronic illness such as type II diabetes (Frideres & Gadacz, 2008; Joe & Young, 1994; O'Neil, 1986; ; Smith, 1999; Wilson, 2008; Waldram et al., 2007). The pathway between oppression and chronic illnesses such as diabetes could include the outcomes of major disruptions in the ways Aboriginal peoples used to live. For example having become less reliant on the land and more so on Western foods and resources and fostered dependence and more sedentary ways of living.

It has been demonstrated in the literature that colonial contact and subjugation continues to have a significant impact of the emotional, physical, spiritual and social well-being of Aboriginal people in Canada and around the world today. The implementation of the Indian Act and well as treaties are good examples of some of the many negative outcomes from colonization. There appears to be strong evidence to suggest that diabetes is in fact a “disease of modernization” (Ferreira & Lang, 2006, 7) or “as a disease of civilization” that was brought upon as a result of significant changes in culture and ways of being for Aboriginal people (Joe & Young, 1993). That being said many of the outcomes of modernization which have had a strong and often negative impact on lifestyle choices have been fully embraced by many Aboriginal peoples whether by choice or as a result of being imposed (Ferreira & Lang, 2006).

Nevertheless these changes have had an impact on the health status of Aboriginal peoples not only in Canada but around the world.

1.1.1 Health status of Aboriginal peoples

It is established that, although this was not always the case, Aboriginal peoples now have a poorer health status compared to mainstream Canadians (Ferreira & Lang, 2006; Frolich et al., 2006; Joe & Young, 1994; Mashford-Pringle, 2011; Reading & Wien, 2009; Shah, 2005; Waldram, Herring, & Young, 2007). The health disparity of Aboriginal peoples has been linked to social, economic, cultural and political inequity (Adelson, 2005). Most would agree that the historical and ongoing legacies of colonialism are ultimately at the root of the problem which has contributed to the inequity and resultant health disparities (Waldram et al., 2007).

In the spirit of holism and Aboriginal views of health I think it is important to address, if only briefly, the emotional, spiritual and social impacts of colonialism on the health of Aboriginal peoples. One of the most recent examples of the impact of colonization are the accounts of Aboriginal peoples who were forced to attend but ultimately survived physical, emotional, sexual, spiritual and cultural abuse in residential schools (Truth and Reconciliation Commission of Canada, 2012, 2015). The trauma that was experienced had a negative impact on the overall health of those who attended and not simply their physical being. As Cote-Meek (2010) points out “wounding of the soul...is evident with survivors of the residential school experience” (Cote-Meek, 2010: 110).

It has been well documented that one of the many outcomes of colonialism and Residential school attendance is intergenerational trauma (Duran & Duran, 1995). It has even been suggested that the effects of residential school attendance not only impacted those who

attended but also those who didn't (Wesley-Esquimaux & Smolewski, 2004). Loss of language, access to the land and essentially being removed and cut off from one's culture are all examples of consequences of having attended residential schools (Kaspar, 2014; Mosby, 2013). Unfortunately there are many others as well but the point to be made is that as a result the impact was not only physical but emotional, spiritual, and cultural.

Diabetes among others is often cited as a disease of westernization brought upon by colonization (Joe & Young, 1994; Maar, 2004). One could make a case that residential school attendance could be viewed as a risk factor for developing type II diabetes given the significant lifestyle changes that occurred while there (Kaspar, 2014). That being said, as Maar (2004) contends:

"(...)the complexity of the impact of colonial forces that have led to ill health in Aboriginal communities are poorly understood from a biomedical and social science perspective... while the notion that stress contributes to chronic illnesses has become accepted from a biomedical perspective, there is no scientific framework to deal with the health effects of complex stressors affecting Aboriginal communities, such as multi-generational trauma or loss of language and cultural identity" (59).

It could certainly be argued that this gap is important enough to consider and should be further explored. Over the last decade there has been increased interest in this area and several studies have revealed that a link between chronic stress such as that likely experienced by those who attended Residential School and the physiological impact that this creates over time can be associated to morbidity and the development of various chronic conditions such as diabetes (Golden, 2007; Lustman & Clouse, 2007; Pirraglia & Gupta, 2007). This area of research will

warrant further attention since the extent of this impact is not fully understood (Bombay, Matheson, & Anisman, 2009).

Although many other diseases and health conditions that extend beyond the physical have been associated with colonization, the focus of this research has been primarily on type II diabetes. A holistic approach and view of health informed by Aboriginal worldviews were considered throughout this study. Having taken the position that it is imperative that a decolonizing stand needs to be taken when considering type II diabetes I believe it would be negligent on my part to not consider Aboriginal peoples who live with type II diabetes beyond the biophysical since other factors such as poverty, dietary changes, and intergenerational trauma as a result of attending residential school have all been linked not only to the development of type II diabetes but to the increased rates amongst Aboriginal peoples in particular (Bombay et al., 2009; Raphael, 2007, 2009).

1.1.2 The extent of type II diabetes in Aboriginal peoples

It is evident in reviewing the primarily bio medically focused literature that diabetes has reached “epidemic proportions among Aboriginal peoples in Canada, with prevalence being 3 to 5 times higher than that of the general population (CDA, 2013; Ferreira & Lang, 2006; Waldram et al., 2007; Young, Reading, Elias, & O’Neil, 2000). Given the increased prevalence of this disease in the First Nation population the associated morbidity and mortality rates are also increased and significant (Statistics Canada, 2006). Complications arising from diabetes include macro and micro vascular conditions such as retinopathy, coronary artery disease, nephropathy and neuropathies and are primarily responsible for the associated morbidity and mortality associated with type II diabetes. According to Hanley et al. (2005) Aboriginal

peoples are also disproportionately affected by complications suggesting that these rates may also be 3 to 5 times higher than the general population.

Type II diabetes is more commonly diagnosed after the age of 30 however Aboriginal peoples are occasionally diagnosed before the age of 10 (CDA, 2013) and in some cases in individuals even as young as five to eight years of age are diagnosed with type II diabetes (Waldram, Herring, Young, 2007). Earlier onset of type II diabetes has been attributed to lifestyle, environmental and cultural factors such as an increased incidence of gestational diabetes, and changes in levels activity and eating habits which have led to an increase in the number of overweight and obese Aboriginal youth (Gahagan, & Silverstein, 2003; Shubair & Tobin, 2010).

It has been suggested that surveys such as the First Nations Regional Longitudinal Health Survey (RHS) and the Aboriginal Peoples Survey (APS) may have in fact underestimated the true prevalence of diabetes because “these surveys provide information on self-reported diagnosis of diabetes by health professionals” and “access to health professionals to diagnose the disease may be difficult in certain remote regions” (Public Health Agency of Canada, 2011, 2). The definition of Aboriginal peoples may also have contributed to a possible under reporting of this disease. As previously noted many definitions of Aboriginal peoples exist and it becomes evident when reviewing the literature that there appears to be a lack of consensus in terminology.

Some authors have suggested that because of significant under reporting, by Aboriginal peoples in Canada and throughout the world, for various reasons including cultural as well as geographical ones, that the incidence and prevalence rates for diabetes among Aboriginal

peoples could be significantly higher than currently being reported (Frideres, 2008; Smylie & Anderson, 2006; Waldram et al., 2007). If this is the case, the problem of diabetes and its impact on Aboriginal people may be even more significant than is currently known. (Bartlett, Iwasaki, Gottlieb, Hall & Mannell, 2007).

1.2 THE BIOMEDICAL MODEL OF DIABETES

In academic research the biomedical representation is often the initial point of reference used to describe an illness (Borovoy & Hine, 2008; Foucault, 1963; Helman, 2000; Illich, 1976). It is my contention that the Western biomedical focus on illness and disease is reductionist since it often fails to take into account the individuals who are affected. This practice has been labelled as medicalizing health which is viewed by some as limiting the field of medicine to a focus on the physical at the expense of other dimensions such as emotional, social, and economic to name a few (Illich, 1976). This perspective is represented and has been well documented as it relates to type II diabetes (Ferreira & Lang, 2006; Pilon, 2008).

Type II diabetes is a metabolic disorder that leads to high blood glucose resulting from either ineffective secretion or action of insulin (Canadian Diabetes Association [CDA], 2013). The disease is characterized by high blood glucose as well as micro-vascular and cardiovascular complications that increase morbidity and mortality and reduce quality of life of individuals living with this chronic illness (CDA, 2013; Burke, Earley, Dixon, Wilke & Puczynski, 2006; Harris, Ekoe, Zdanowicz & Webster-Bogaert, 2005).

Diabetes has been classified into three separate types: type I, type II and gestational diabetes mellitus. For the purposes of this discussion, the focus will be on type II diabetes since it is by far the most common form of diabetes affecting Aboriginal peoples. Aboriginal women

are 5 times more likely to develop diabetes and Aboriginal men are 3 times more likely to develop diabetes compared to their non-Aboriginal counterparts. Aboriginal women are therefore at higher risk of developing type II diabetes (Waldram et al., 2007). Type II diabetes is proposed to occur as a result of insulin resistance, decreased insulin secretion, or excess production of glucose from the liver (CDA, 2013). Conventionally type II diabetes is treated with lifestyle modification diet and exercise. As the disease progresses the addition of insulin sensitizers, oral hypoglycemic agents and insulin are required to achieve optimum glycemic control, the central goal of diabetes management. Since co-morbidities such as renal failure often develop in individuals with type II diabetes the control of blood pressure and cholesterol are often also incorporated into the management of this disease further illustrating the complex nature of this disease (CDA, 2013).

There are many risk factors associated with diabetes and these include biological factors such as higher rates of obesity in Aboriginal peoples as well as higher rates of gestational diabetes than non-Aboriginal women and lifestyle factors such as unhealthy eating, physical inactivity, and being overweight or developing obesity (Public Health Agency of Canada, 2011) Another important yet often overlooked risk factor is poverty (Chaufan & Weitz, 2009) and Raphael (2007) suggests is perhaps the best predictor of developing type II diabetes . Many of these factors have guided the path of much of the inquiry that has taken place. Attributing a cause for diabetes is often considered and has led to the development of various theories of causation.

1.2.1 *Theories of causation of diabetes in Aboriginal peoples*

Many theories have been postulated for the increased incidence in this particular population. A strong genetic predisposition and a link to obesity have also been identified (CDA, 2013; Yu & Zinman, 2007). Some have suggested that too much emphasis has been placed “on elusive, racially-based genetic models to explain this inequality” with respect to higher rates and poorer outcomes compared to non-Aboriginal counterparts (Maar et al. 2011).

The role of genetics was initially presented by Neel (1962) who introduced what has become known as the thrifty gene theory. He based his hypothesis on the evolutionary notion that hunter/gatherer populations such as Aboriginal people survived by feast and famine living conditions based on their ability to accumulate and store fat. Unfortunately this un-testable hypothesis has been blindly accepted by many over time and even continues to be referenced to this day. Others did challenge this way of thinking and as a result many years later Neel changed his view from a genetic predisposition to make a greater link to lifestyle changes (Neel, 1999). Nevertheless scholars such as Poudrier (2007) disagree with Neel and have since challenged this theory arguing in part that it was too simplistic and racist because it failed to take into consideration other important factors such as colonialism. It is without question that Aboriginal peoples have experienced drastic changes in lifestyle especially as a result of European contact (Joe & Young, 1998). That being said, reducing the cause to a simple theory of causation such as the one suggested by Neel is viewed as too simplistic by many (Maar et al., 2011). It has been suggested that the focus should not be limited to genetic causes but should also include the consideration of important environmental factors such living conditions and even exposure to stress (Byrne & Nkongolo, 2011).

The emphasis on the etiology of diabetes fares quite prominently in most of the diabetes related literature however the causes often fail to once again take into consideration the actual impact of various social determinants of health such as poverty and more specifically colonialism (Chaufan & Weitz, 2009) . Ferreira and Lang (2006) have suggested that this is possibly because there is a:

“(..)deliberate attempt to ignore the macro-social context in which diabetes originates and the political economic aspects of its geographic distribution across so many groups of Indigenous peoples around the world. Variables such as environment, culture and emotion, are often rejected as metaphysical, or else when cited, considered ‘too complex’ or sometimes just too problematic to be worth the time” (8).

Raphael (2007, 2009) advances a similar argument for considering social determinants of health when conducting diabetes research. This way of thinking has certainly situated the positivist agenda in a position of power and perhaps even control when it comes to diabetes research in Aboriginal peoples. What seems to be missing is further elaboration on the environmental aspect that has primarily been imposed by European contact and colonial ideology.

As a result of the disproportionate rates of this form of diabetes in Aboriginal peoples the biomedical community has often tended to focus on ‘heritage’ and ‘genome’ as risk factors “to help explain disparity rates in the prevalence of type II diabetes” (Ferreira & Lang, 2006: 9). This way of thinking, which is considered too simplistic and even racist by some, has promoted the need to redefine diabetes shifting away from the traditional biomedical understanding of the disease to new understandings such as Aboriginal models and ways of

knowing (Ferreira & Lang, 2006; Joe & Young, 1993) as well as considering the role of social determinants of health (Raphael, 2009). One way to accomplish this shift in focus might be to consider certain social determinants as being implicated in the higher rates of diabetes such as living conditions and income (Frohlich, Ross, & Richmond, 2006).

Ferreira & Lang (2006) have criticized the fact that diabetes in Aboriginal peoples is often viewed as hereditary and linked to genetics. They have suggested that ultimately it has resulted from genocide and colonization. This notion is supported by Frohlich and his collaborators (2006) who stated that “the burden of health and social disparities borne by Aboriginal Canada are rooted fundamentally in colonialism and their historical position within the Canadian social system” (Frohlich, et al. 2006:136).

Ferreira & Lang (2006) have suggested that there is a move towards dispelling “etiologiical explanations that adhere to a genetic determinism of diabetes-a reductionist view for a complex condition that has been virtually non-existent for many worlds peoples until the past 60 or 70 years” (7). They further argue for a redefinition of diabetes and what it means for Aboriginal peoples. Based on my experience and observations I suggest that the reductionist and positivist views and explanations of type II diabetes have also been adopted by many Aboriginal peoples themselves who have simply accepted them at face value. As Chaufan and Weitz (2009) point out this lack of questioning may result because,

“(...)explanations for diabetes and its complications overwhelmingly emphasize features of patients (their biology, behaviours, psychological states, or culture), focus on identifying ‘risk factors’ and recommend ‘targeting’ and changing individuals, while failing to challenge risk-producing environments and reframing, neglecting or ignoring

the links between poverty and disease. These discursive strategies, by concealing the impact of poverty, naturalize higher rates of diabetes among poor persons and legitimize relations of domination in the larger society” (76).

In other words, acceptance without questioning may suggest agreement when that may not necessarily be the case. Lack of questioning might simply suggest a lack of awareness of the role that external factors might play.

Chaufan and Weitz (2009) contend that “socioeconomic explanations for the high rates of diabetes found among poor persons, whether minorities or non-minorities, are considerably less common” (79). Ultimately there is a need for researchers to reformulate underlying assumptions about health and illness which needs to be reflected in research methods (Bartlett et al. 2007). As Young and collaborators (2000) have suggested “diabetes is not simply a metabolic disorder that can be adequately dealt with on an individual basis in a clinic or hospital ward. Its prevention and control require community action and collaboration among Aboriginal organizations, governments, voluntary agencies and health care professionals” (Young et al., 2000: 565). The bottom line is that the onset of disease correlates with changes in lifestyle and cultural practices that were brought on by the impact of colonization (Waldram et al., 2007; Ferreira & Lang, 2006; Joe & Young, 1994). There is a need to clearly understand the impact of subjugation and cultural difference on lifestyle in order to develop education and prevention programs that are beneficial and culturally relevant for Aboriginal people living with type II diabetes.

Several researchers have considered the question of causation in a more culturally appropriate manner with a particular emphasis on exploring personal theories from the

perspective of Aboriginal peoples themselves. For example Hagey (1984) found that clients who attended an urban diabetes program in Toronto attributed the development of their diabetes to European contact and this influenced the way they ate, accessed the land, from alcoholism, and as a result of lacking spiritual strength. Similarly Garro (1995) who interviewed Aboriginal peoples in a Manitoba First Nation community uncovered two types of explanations for the development of diabetes. The first was to blame oneself for the way they lived and the second explanation was attributed to the “White man for polluting the environment and contaminating food sources” (Garro, 1995, 221). Some of the participants in her study also seem to attribute heredity as a cause. Finally Lang (1989) came to similar conclusions about causation during a study involving Dakota Indians. What was interesting in that particular study was that many of the participants also believed that since diabetes was a relatively new disease introduced by the ‘white man’ it could not be treated with traditional medicines. All three of these studies considered the impact of colonialism on the development of diabetes.

It is abundantly clear in reviewing the literature that contemporary definitions of diabetes are problematic since they are based on Western ideologies (Rock, 2003). This predominantly Western approach to diabetes has led to the development of theories of causation as it relates to the development of diabetes amongst Aboriginal people. Trying to understand diabetes primarily from a biomedical perspective is not only limiting but also problematic especially for Aboriginal peoples. Sunday et al. (2001) discovered in their work on Manitoulin Island that when it comes to causation and diabetes, biomedical and Aboriginal perspective can often be divergent.

Some researchers have attempted to distance themselves from prejudiced and oppressive attitudes that focus on race rather than considering sociopolitical factors brought about by colonization. Although funding in the areas of Aboriginal health have improved over the last decade most of the research funding has historically been attributed to research focusing on the pharmaceutical treatment of diabetes (Ferreira & Lang, 2006). Kulig and Williams (2012) have suggested that one of the reasons that CIHR funding for rural health research is limited is that there is no one within this funding body who is solely responsible for rural health related research. As a result, the CIHR has historically allocated a very small percentage of its budgets to the rural sector in which most of the Aboriginal health related research tends to be situated. It could be argued that politics and policy have had a major impact on determining the direction in which Aboriginal diabetes research has taken.

1.3 SOCIOPOLITICAL DIMENSION OF DIABETES

Health status is often influenced by outside “socio-cultural, political and economic forces” (Baer, Singer & Johnson, 1986). It has been well documented that Aboriginal people face considerable social, economic, environmental and health care access issues compared to the general Canadian population (CIHR, 2004; Reading, 2009; Waldram et al., 2007) as a result of colonization (Smith, 1999; Waldram et al, 2007). This ultimately has resulted in acculturation (Skye, 2010; Varcoe, 2008), changes in diet, residence, spirituality (Kurtz et al., 2008), and the decline in the use of language to name a few (Waldram et al., 2007). All of these factors have negatively impacted many of this population’s determinants of health.

1.3.1 *Canadian health policy impact on Aboriginal health*

In addition to previously identified social determinants of health (Raphael, 2007) it has been suggested by some that colonization and residential school attendance should also be considered as social determinants of health for Aboriginal peoples (Czyzewski, 2011; Jacklin & Warry, 2012; Reading & Wien, 2009; Shah, 2005). Ultimately it could be argued that colonization has resulted in overall inequity in terms of health status and access, income, and education (N.A.H.O., 2005; Kirmayer, Bass, & Tait, 2000). Government policy and even inaction has contributed to the high incidence of type II diabetes in Aboriginal peoples (Pilkington et al., 2011; Wilson, Rosenberg, & Abonyi, 2011; Pilkington et al., 2010; Shubair & Tobin, 2010). Perhaps one of the most pertinent examples of harmful government policy is the Indian Act (Reading & Wien, 2009).

The Indian Act which was enacted in 1876 and revised in 1951 under the Canadian Constitution became a piece of legislation that would set out many of the provisions, rules and definitions used by the government to formally and legally continue its agenda of domination, control and forced assimilation of Aboriginal people (Emberley, 2007; ; Kelm, 1998; Waldram et al., 2007). It also set out to define among other things ‘who’ would be legally recognized as an “Indian” and where they would live.

Reserves were legally defined and all of the rules and regulations with respect to how this land was to be occupied and utilized were spelled out in detail in the Act (Government of Canada, 1985). In fact this extremely paternalistic act set out to delineate every single social, political and economic aspect of how Aboriginal people

were to live and conduct themselves. This eventually had a significant impact on Aboriginal peoples' access to the land and, ultimately, the way in which they ate. There appears to be very little cultural consideration as a result of this Draconian law. The Indian Act also addressed the issue of health care for Aboriginal peoples.

Although provincial governments provide services to Aboriginal peoples, unlike mainstream Canadians, health care for Status Indians who live on reserves is primarily funded by and is the responsibility of the federal government (Brooks & Miljan, 2003). This can be seen as problematic and even as establishing two levels of health care in our country, that is, provincial and federal. This system is funded by the federal government and administered by Health Canada's First Nation and Inuit Health Branch. The services and funding agreements under this program are complex and beyond the scope of this thesis. Suffice it to say that the health care funding arrangement for Canada's Aboriginal peoples, particularly in Ontario, consists of silos of federal and provincial funding streams that commonly lack tripartite planning and consequently struggle to achieve efficient administration and service integration (Marchildon, 2006).

The National Collaborating Centres for Aboriginal Health (NCCAH) (2009) drafted a report that provides a critique and highlights the problems and complexities with Canada's health policies that are founded on "historically vague legislation" (32). The complexities are compounded by confusion over who provides and who is responsible for the delivery of health care to Aboriginal peoples. The problems are further compounded by the existence of thirteen different provincial and territorial healthcare systems and varying health delivery models.

The development of Aboriginal policy in Canada has been influenced by many key moments. For example in the pre-Confederation era to the 1960s the government agenda was to foster dependency and assimilation. By 1969 the White Paper was released and promoted integration and equality however some have argued that [it] “simply continued along the assimilationist path of previous federal policies, but with a vengeance” (Brooks & Miljan, 251). In 1996 the Royal Commission on Aboriginal Peoples (RCAP) promoted the notion of Aboriginal peoples as separate yet equal members of Canadian society. This report started on the premise that Aboriginal Canadians constitute First Nations whose sovereignty should be respected by the government of Canada. Many of the recommendations set out by the RCAP have yet to be implemented (Browne, Smye & Varcoe, 2005; Waldram, Herring, & Young, 2006).

In spite of the Federal government’s role with respect to Aboriginal health and fiduciary responsibility, problems of inequity, access, and funding continue to exist. According to NAHO (2009): “the ongoing restrictions placed on Aboriginal self-government, land claims and economic development in many First Nations communities, shape the overall health, wellbeing and quality of life in communities. These, in turn, shape life opportunities, economic conditions, and the overall health and social status of First Nations individuals, families, and communities” (25). In spite of the 1980s transfer of responsibilities from the Federal government to First Nations it could be argued that true self-determination and control over health care and services for Aboriginal people has not yet occurred and this has translated into poorer health overall compared to mainstream Canadians (Ferreira & Lang, 2006; Frolich et al., 2006; Joe & Young, 1994; Reading & Wien, 2009; Shah, 2005; Waldram, Herring, & Young, 2007). The prevalence

of type II diabetes is one of many such examples of poor health outcomes for Canada's Aboriginal peoples. Most if not all of these negative outcomes for Aboriginal peoples can be attributed to the historical and ongoing legacy of colonialism which many view as an Aboriginal specific determinant of health (Jacklin & Warry, 2012; Shah, 2005).

Until recently, what has been missing from most of the discourse surrounding health is the role that traditional healing practices and medicines that were accessed and utilized by Aboriginal peoples prior to European contact. It wasn't until the early 1990s for example through such initiatives as the Aboriginal Healing and Wellness Strategy (AHWS) that the Ontario provincial government started to promote Aboriginal empowerment by beginning to share the control over community based health care services (Maar, 2004). Although there appears to be a resurgence of the use and access to traditional healing and medicines over the last two decades, the uptake has been slow for many reasons. This is supported by Ross (2014) who suggests that after many years of exposure to Canadian governmental policies and health care models, familiarity with and confidence in traditional Aboriginal ways of managing health have all but been eroded..

It has been suggested that social determinants of health and policies need to be considered in order to reduce the incidence of type II diabetes as well as improve the care for Aboriginal peoples who live with this disease (Pilkington et al., 2010, 2011). Since nutrition and dietary practices are closely related to type II diabetes management it might also be important to consider how policy has and continues to influence the way in which Aboriginal people access and consume food and what impact this has had.

1.3.2 *Policy influence on ways of eating*

According to Earle (2011), “Aboriginal peoples in Canada have undergone a significant nutritional transition whereby traditional diets and associated physical activities have been replaced with patterns of consumption that increase the risk of developing chronic disease” (1). When using the term ‘traditional’ with respect to diet what is often meant is the ways in which Aboriginal peoples “harvested, hunted and prepared the plant and animal food sources native to [the] homelands prior to invasion” (Wazayatawin, 2005, 76). Type II diabetes is one of many examples of chronic illness development that has been linked to diet. There are various reasons for this transition and most of these are linked to European contact and its ensuing colonial impacts of modernization and commercialization (Kuhnein & Receveur, 1996).

The ways in which Aboriginal peoples now eat have been significantly impacted and the amount of traditional food being consumed has decreased. This is attributed to the introduction of reserve rations, a loss of access to the land and hunting, and the development of a dependence on market foods (Kelm, 1998; Turner & Turner, 2008). It has also been argued in the literature that changing ways of eating have also been influenced by the fur trade, land cessions, and Christianization which are all examples of an externally imposed change in the way of living (Kelm, 1998; Scott, 1985). Ironically in the beginning Europeans were quite dependent upon Aboriginal peoples and their resources but after centuries of colonization it is Aboriginal peoples themselves that have been made to become dependent on colonial settlers (Waldram et al., 2007). Similarly government policies such as the Indian Act have contributed in significant ways from legislation that governs access to and utilization of the land to laws that forced children to be taken away to residential schools against their parent’s wishes essentially being cut off from

their culture and traditional ways of living (Emberley, 2007; Kelm, 1998; Kuhnlein, 1992; Waldram et al., 2007).

Turner and Turner (2008) have also suggested that the decreased use of and dwindling cultural knowledge regarding the use of some plants that were part of the diet in the past as a result of such factors as

“changing knowledge systems owing to religious conversion and residential schools, loss of Indigenous languages, loss of time and opportunity for traditional practices owing to participation in the wage economy, increasing urbanization of indigenous populations, loss of access to traditional resources, restriction of management practices for sustaining these resources, and most recently, forces of globalization and industrialization” (103).

Most if not all of these outcomes occurred as a direct result of government policy that had a direct and deleterious impact on Aboriginal peoples’ ways of living. There is no question that the disruptions that transpired have had a negative impact on the health and well-being of Aboriginal peoples as manifested by the increased incidence of type II diabetes amongst this population.

1.3.3 Canadian health policy limitations related to diabetes care in Aboriginal peoples

According to Reading and Wien (2009) the imposition of colonial institutions, systems, and lifestyle disruptions has led to a decrease in self-determination and lack of influence on health related policies especially as they pertain to Aboriginal peoples. Brooks & Miljan (2003) further argue that “in Canada, as elsewhere in the world, there is a real need to come to terms with our past as an imperialist settler society built on the dispossession and marginalization of

indigenous peoples” ...and “being open to the sorts of policies that satisfy Aboriginal Canadians’ legitimate demands for recognition of their differences” (259).

Conversely Flanagan argues that recognition of the colonial past has in fact taken place as a result of “the successful politicization of Aboriginal identity” (Flanagan, 2012: 259). In other words according to Flanagan it is clear, at least to him, who Aboriginal peoples are. I would suggest that his perspective is rather limited and primarily influenced by his neo-conservative roots because if true recognition of the historical and ongoing impacts of the colonial past had in fact been addressed, we would see more evidence of restitution which extends beyond reconciliation. Brooks and Miljan (2003) have suggested that the “lack of consensus on what should be done virtually guarantees that Aboriginal policy will continue to be a political minefield in Canada” (Brooks & Miljan, 2003: 260). Flanagan and Cairns provide a good example of different and competing views in government with respect to Aboriginal policy. Given the opposing views is it any wonder that Aboriginal health policy is in the state that it is? Cairns who is a non-Aboriginal political scientist has focused extensively on the question of citizenship in the Canadian federation which is considered to be integral when it comes to the topic of Indigenous rights and citizenship. Flanagan on the other hand, who is also a non-Aboriginal political scientist, and, who has served as an Advisor to Prime Minister Stephen Harper has long focused his career on challenging Metis and Native rights and has clearly declared his neo-conservative views. It would also be important to add that Flanagan is considered by many to continue to promote the assimilation and colonial agenda of past and even current Canadian governments.

As Warry (2007) pointed out “neo-conservative arguments often begin by suggesting that the ‘poverty, misery and despair’ of Aboriginal communities is evidence of failed government policies. The neo-conservative right and the liberal left agree about one thing: the ill health of First Nations is proof positive that radical change is needed. The question is what type of policies should be pursued: those that promote self-government or integration into the mainstream” (151). He goes on to suggest that “First Nations are slowly building capacity in health and social services, despite the failure of the federal government to significantly invest in rural and remote care” (Warry, 2007, 151). This latter statement by Warry (2007) would seem to suggest that Aboriginal peoples are perhaps more capable and willing to ‘take control’ of their health care services once and for all. The missing ingredient seems to be the political will to provide funding that would actually enable Aboriginal peoples to self-govern and become self-determined once and for all. .

The social dimension of type II diabetes for Aboriginal peoples which has been significantly impacted by colonial history and policy is particularly important to consider. Significant changes in lifestyle, the environment and culture over the last fifty years have contributed to the notion that diabetes is a disease of acculturation (Garcia-Smith, 1994; Hegele, 2001; Smith, 1999; Waldram et al., 2007). Access to the land, ways of eating and traditional health practices have all been impacted and forever changed for Aboriginal peoples. As a result some of the more recent work done in the area of type II diabetes new research has emerged exploring some of the social, cultural, and political aspects. Examples of this body of work will now be presented.

1.4 *Empirical perspective*

Research in the area of type II diabetes has been considered from various perspectives and by various disciplines (Wilson & Young, 2008). These perspectives include biomedical, genetic, epidemiological, psychological, social and anthropological. There appears to be a significant body of work that has been done by the disciplines of medicine and epidemiology. This certainly appeared to be the case as demonstrated by a review done by Young in 2003 which concluded that a majority of the research conducted in the areas of Aboriginal health is often carried out by the discipline of medicine (Wilson & Young, 2008). Medicine's main focus, which is influenced by primarily biomedical explanatory models of health, has historically been to attempt to identify the etiology of illness, and uncover methods of treating illness. Few of these studies have considered diabetes beyond the traditional biomedical perspective and they often fail to address or consider the impact of colonization.

Most of the data from research related to diabetes in Aboriginal people has been generated by the United States followed by Canada which has been publishing extensively in this area over the last twenty years in response to the increasing prevalence and burden of this disease among Aboriginal Canadians (Barton, 2008). As previously noted much of the available literature and indeed the focus of much research related to diabetes has been driven and focused on the biomedical aspects of the illness. Ross, & Richmond (2006) suggested that there needs to be more focus on factors that contribute to social inequities "rather than focusing on the disparities of health alone" (Frolich, Ross, & Richmond, 2006: 132). It is therefore important to situate diabetes in its appropriate historical, political, and sociocultural contexts.

The purpose of this review of the literature was to uncover what is presently known with respect to providing type II diabetes care to Aboriginal peoples who have been colonized with an emphasis on the interdisciplinary literature. The goal of the study is to change and ultimately improve the practice of health care providers by using a decolonized approach when participating in the care of Aboriginal peoples who live with type II diabetes. In reviewing the empirical literature with respect to type II diabetes in Aboriginal people it becomes readily apparent that questions dealing with why this is such a problem abound. As a consequence of this line of inquiry, much of the focus of researchers has been on establishing theories and attempting to explain why the incidence of diabetes is so elevated in this particular population. What seems less well understood is how to provide the best and most culturally appropriate diabetes health care services to Aboriginal peoples.

It is well known that management of type II diabetes can be challenging (CDA, 2013). This is particularly true for Aboriginal peoples in light of various factors such as cultural, historical, social, economic, and political factors that are particular to this population as a result of historical and ongoing colonial practices. Health care providers, especially those who are non-Aboriginal and who do not live with type II diabetes, are particularly at a disadvantage in providing care to Aboriginal peoples since they are not intimately connected to the complex context bound reality of Aboriginal peoples. It has been suggested that employing a decolonized approach when it comes to such activities as research for example are required. The question then becomes how the traditional primarily biomedical focused approach to type II diabetes in Aboriginal people can become decolonized.

Therefore in order to gain a better appreciation of the impact of colonization on type II diabetes in Aboriginal peoples this review included original scholarly work that was qualitative in nature, conducted in Canada over the last twenty years and considered the impact of colonization. I will begin by presenting several qualitative studies that have been published primarily in Canada between 1995 and 2007 and conclude with an overall impression regarding the contributions from this body of works.

1.5 Research focussing on decolonization

The western biomedical perspective has focused on physical dimensions such as genetics, nutrition, and activity levels in treating and preventing diabetes (Sunday, Eyles, & Upshur, 2001) whereas Aboriginal ways tend to hold a more holistic view and focus more on a balance between the physical, mental, emotional and spiritual aspects of individuals (Nabigon, Hagey, Webster & MacKay, 1984; Webster & MacKay, 1999;). This philosophy has undoubtedly influenced the focus of much of the research that has been conducted in the areas of illness prevention and health promotion strategies related to type II diabetes in Aboriginal peoples. There is also a movement to promote more participatory approaches to conducting research with Aboriginal peoples by utilizing a decolonizing approach in order to strive for the creation of interventions that are more culturally specific (Struthers, Schanche-Hodge, Geishirt-Cantrell, & De Cora, 2003) and inclusive of Aboriginal perspectives (Barton, Anderson, & Thommasen, 2004). This is especially important because “historically, research conducted on indigenous peoples has been inappropriate because it has often served to advance the politics of colonial control” (Cochran et al., 2008: 22). Much of the more contemporary

work in this area has attempted to distance itself from the colonial past by changing the way research is approached.

For example in a study by Bruyere and Garro (2000) it was reported that: “While health professionals tend to localize diabetes within individual bodies, the participants viewed diabetes as rooted in collective experience and in historical processes that have impinged on Aboriginal People and are beyond their control” (Bruyere & Garro, 2000: 26). This notion was also supported by Reading and Wien (2009) who shared that “this is particularly true for Aboriginal peoples, who have historically been collectivist in their social institutions and processes, specifically the ways in which health is perceived and addressed” (Reading and Wien, 2009: 3). The importance of culture and participation in the process are both essential and often the focus of many of the studies that have been conducted in the area of type II diabetes in Aboriginal peoples.

In a grounded theory study Hernandez and colleagues (1999) sought to explore the experience of type II diabetes of ten Aboriginal peoples living in a southwestern Ontario First Nation community. Some of the key findings from this study included the “desire to live in harmony with nature and cooperation with others” and the importance of receiving their diabetes health education from an individual who had diabetes not from their own community and not necessarily Aboriginal. The importance of self-determination, which is one of the key features of decolonization, was also addressed in this study (221).

Struthers and collaborators (2003) conducted a phenomenological study with two Northern Plains American Indian tribes that described their experiences of participating in ‘talking circles’ on type II diabetes. It was suggested that traditional Western methods of

delivering diabetes care were ineffective and culturally inappropriate. These researchers concluded through the emergence of seven common themes that the talking circle approach provided an effective and culturally appropriate method of sharing diabetes information with participants at the community level. This was the only related study that was not Canadian.

In order to determine how to inform diabetes health related services for Aboriginal peoples living in a northern British Columbia First Nation community Barton et al. (2005) performed content analysis on interviews they conducted with eight Nuxalk Nation participants. The study identified several challenges that existed in connecting diabetes with such things as Western and Traditional ways, diet, communication with their providers, and how life choices and daily living are linked. The researchers concluded that Aboriginal peoples need to be involved in the development of diabetes related health services.

A few years later Barton (2008) used a narrative inquiry approach that was based on hermeneutic phenomenological philosophy to elicit the diabetes self-care experiences in four Aboriginal peoples once again living in a northern British Columbia First Nation community. This study revealed three key insights that included the fact that the diabetes experience is different for Aboriginal peoples compared to non-Aboriginals that the way in which the participants understood their diabetes experience is related to time, place, body and relationships and connected to their pasts and presents, and finally that mutual respect and caring towards one another are important. It was suggested that the findings from this study could help expand the understanding of diabetes and could help inform future research within that specific cultural context.

Barton (2008) also provided a comprehensive review of 26 community based Aboriginal diabetes studies conducted in Canada between 1995 and 2007 that were considered to be inclusive of the Aboriginal perspective as well as considering the values and priorities established by the communities that participated. Most of the provinces were represented however Alberta, Prince Edward Island, New Brunswick, and Newfoundland as well as the territories were excluded. The majority of these studies, that is 15 of them, were conducted in Ontario and Quebec. The goals of these studies included such things as evaluating program effectiveness, gaining a better understanding of Aboriginal perspectives and meanings related to diabetes, the sociocultural origins of diabetes, and reporting on a community based participatory research project that was conducted in the First Nation Mohawk community of Kahnawake. All of the studies included in this comprehensive review were considered to have moved away from colonial research methods and having adopted decolonized research methodologies.

Maar and colleagues (2011), using a participatory approach with focus groups in a research project that was conducted on Manitoulin Island, explored the underlying socio-political factors that were believed to interfere with effective diabetes care in Aboriginal communities. A number of barriers that contributed to poor outcomes such as diabetes related complications were presented including but limited to the importance of language, health literacy and lack of cultural safety. Their recommendations which were aimed at the reduction of diabetes related complications focused in the areas of patient education and services. Although not explicitly stated in the conclusions this group of researchers appeared to be advancing the notion of taking a more decolonized approach to type II diabetes care for Aboriginal peoples.

Manitowabi & Maar (2013) reached similar conclusions in their work that explored the impact of colonization through an examination of Aboriginal peoples' understandings of the pathways or contributing factors that contribute to diabetes that extend beyond the physical to consider socio-political factors. Both of these works appeared to be concerned with the impact of colonization and structural violence on the diabetes experience for Aboriginal peoples in an area that is both geographically and culturally closely related to the Aboriginal communities that were the focus of this study.

There is evidence that work is being conducted in the area of type II diabetes in Aboriginal peoples that extends beyond the biomedical perspective. However no one seems to have considered or asked questions that explore how type II diabetes care itself can be decolonized. This is possibly because often the locus for change as it relates to diabetes care is often focused on the individual instead of considering how changing health care providers and the health care system itself might help to improve care (Chaufan & Weitz, 2009). No one appears to have looked at how considering various aspects could help with the development of a more decolonized model of diabetes care for Aboriginal peoples.

1.6 Gaps in the literature

. The way in which diabetes is understood and conceptualized by Aboriginal and non-Aboriginal people, as well as considerations of the historical and ongoing impact of colonization, are often lacking in the work that has been reviewed. The way in which this has impacted the lifestyle and ways of living needs to be better understood and how this is linked to the development of type II diabetes especially in Aboriginal peoples. It could also be argued that the research presented has primarily focused on more conventional approaches to diabetes health

care and less so on the role that traditional healers and medicines could play in relation to type II diabetes care in this particular population.

There appears to be a paucity of research that has examined the impact of colonization on the lived experience of type II diabetes for Aboriginal people. We also know very little about the impact of a predominant western and biomedical model approach to managing this disease when it comes to Aboriginal peoples. This longstanding approach to illness prevention and disease management, which is firmly rooted in a positivist paradigm, fails to consider the relationships between the oppressed and their health status and one might even argue to consider alternate ways of addressing health and illness (Iwisaki, Bartlett, & O'Neil, 2004; Smye & Browne, 2002). It is important that Aboriginal peoples' experience with diabetes be situated "within its historical, socioeconomic, and political context...to deconstruct diabetes as it is currently understood in order to "situate diabetes within a complex landscape that extends beyond conventional biomedical and clinical understandings into the realm of social justice and emotional liberty" (Ferreira and Lang, 2006: 3).

Since most of the existing knowledge and research has been from a predominantly Western/European perspective and that Aboriginal people seem to be affected in a disproportionate way it has become imperative that we consider Aboriginal worldviews as they relate to health and illness (Prior, 2007; Rock, 2003; Smith, 1999; Sunday, Eyles, & Upshur, 2001; Wilson, 2008). These worldviews include new ontologies and epistemologies that represent post-colonial indigenous thinking (Browne & Smye & Varcoe 2005). As suggested by Reading and Wien (2009) "Indigenous ideologies embrace a holistic concept of health that reflects physical, spiritual, emotional, and mental dimensions" and "it is the interrelatedness of

these dimensions that is perhaps most noteworthy” (Reading & Wien, 2009: 3). It has also been demonstrated that there is a need to better integrate traditional Aboriginal and western medical views in order to develop protocols for service delivery that ensure the integrity of both systems (Maar et al, 2011; Maar and Shawande 2010; Mignone, 2009). Although the suggestion has been made it would appear that we are only beginning to explore the need and importance of providing type II diabetes care to Aboriginal peoples that is based on the principles of decolonization.

There needs to be far greater emphasis placed on examining the social causes or contributing factors for diabetes rather than an overreliance on the biological factors as evidenced by the overabundance of predominantly biomedical available research conducted in the area. This can only be achieved by conducting engaging and collaborative research with those impacted by diabetes while remaining cognizant of the importance of not continuing to perpetuate imperialistic, dominant and colonial attitudes but rather striving for a truly post-colonial and decolonizing approach to better understanding what it is like for contemporary Aboriginal Peoples to live with this illness.

In the next chapter I will present and discuss the theoretical underpinnings for this study as well as describe the conceptual framework which were influenced by the extensive review of the literature and ultimately served as a guide in developing the research design.

CHAPTER TWO:

THEORETICAL AND CONCEPTUAL FRAMEWORKS

The aim and purpose of this chapter is to provide an overview of the ontological (what we believe the world is made of), epistemological (how we come to know what we know), and theoretical influences for this study. Every researcher has a philosophical position or stance on which he or she is positioned. It is this perspective that ultimately informs and guides the researcher through the process of conducting research and exploring a phenomenon of interest (Mills & Birk, 2014).

I must admit that I found this particular chapter perhaps the most challenging to write since it forced me to make explicit what has been implicit and imbedded into my subconscious. It wasn't until I realized the importance of being able to understand and clearly articulate my personal philosophical perspective that I was able to begin to appreciate how my interest and understanding of the experience of living with type II diabetes for Aboriginal people came to be and evolved over the course of my career as a Nurse Practitioner. My extensive review of the literature in the areas of Aboriginal and Western philosophy, ontology, and epistemology has provided me with the ability to present, through the use of academic discourse, not only the lens through which I view the world but also my reasoning and justifications in conducting a methodologically correct research project.

A theoretical perspective provides the philosophical stance on which this study has been based. The major theoretical underpinnings and influence for this study are social constructivism which is framed by colonization, post-colonialism and decolonization. Given the historical legacy and ongoing impact of colonization, underpinning this study with a

constructivist framework consisting of a post-colonial and decolonizing approach is not only important but necessary (Gandhi, 1998).

2.1 Qualitative Studies using a Constructivist Approach

A qualitative constructivist research approach which is “a social scientific perspective that addresses how realities are made. This perspective assumes that people, including researchers, construct the realities in which they participate...Constructivists acknowledge that their interpretation of the studied phenomenon is itself constructed” (Charmaz, 2006, 187). This approach can ultimately generate knowledge that is seen to reflect the reality of individuals and groups (Creswell, 2003). The purpose of utilizing a qualitative approach is to render that which is often implicit more explicit through the use of social constructivism and the use of participant`s own words. Furthermore, as a result of not only the historical but ongoing impact of colonialism, one should ideally consider the phenomena of living with type II diabetes from a post-colonial and decolonized perspective.

In this case, by employing a qualitative constructivist approach I am attempting to explain, interpret and make sense of what I consider to be the complex social phenomenon of living with type II diabetes from the perspective of Aboriginal peoples who have been impacted by colonization. The only way to gain an understanding of this reality, that is, the ontological perspective of Aboriginal people who have diabetes, are to ask them to explain and describe their experiences and by interpreting and giving meaning to what they are telling me.

Recording and analyzing their responses allowed me to generate knowledge or an understanding to help give new meaning to their particular experiences. Thus my epistemological perspective is that the participants in this study are the sources of knowledge

that will help me to give meaning to their complex context bound realities of living with type II diabetes, or in other words construct their reality.

2.2 Epistemological perspective of knowledge

In order to engage into a discourse on Indigenous knowledge it is important to begin by exploring and gaining a better understanding of Aboriginal worldviews and how these differ from Western worldviews. Poonwassie and Charter (2001) suggest that “worldviews emerge from the totality of peoples’ social, political, economic, cultural and spiritual perceptions and beliefs” (Poonwassie & Charter, 2001: 64). It is these worldviews that ultimately inform ontological and epistemological perspectives ultimately informing postcolonial theory. The way in which we view and experience reality as well as what is considered to be knowledge is different for Aboriginal peoples (Battiste, 2000; Johnston, 1976; Ross, 2014; Spielman, 2009).

A worldview is essentially one’s philosophy or way of life. According to Poonwassie & Charter (2001) significant differences exist between European and Aboriginal worldviews. It is these worldviews that ultimately inform ontological and epistemological perspectives as well as postcolonial theory. The way in which we view and experience reality as well as what is considered to be knowledge is different for Aboriginal peoples (Ross, 2014; Spielman, 2009; Battiste, 2000; Johnston, 1976).

Spielman (2002) points out that some of the values and traditions that exist today may not be the same as those of their ancestors since Aboriginal peoples “have endured a few hundred years of assault on their culture” however they are likely strongly influenced by them (Spielman, 2002: 25). The outcome of such colonial impact has been described as having developed ‘hybrid ways of thinking and knowing’ (Lawrence, 2004).

Although changing values and traditions was considered for Aboriginal peoples who tend to live in more urban centres and have been strongly influenced by Western ways it could be argued that the close proximity of urban centres to the First Nation communities along the North Shore of Lake Huron may have had a similar impact. The city of Sudbury is only a few kilometers from the eastern end of the NSTC region, and the city of Sault Ste. Marie constitutes the western edge of the region in which these communities are located. These worldviews also influence ontological and epistemological perspectives and ultimately what constitutes as traditional or Indigenous knowledge. It is important to gain a better understanding of these perspectives before launching into a discourse on Indigenous or Traditional knowledge. Before proceeding I would like to point out that for the purposes of this discussion I have elected to use the term traditional knowledge from this point on.

There exist many definitions and explanations of what constitutes traditional knowledge. I believe that it is important to provide a definition that has been developed by Aboriginal peoples themselves and for that reason I have elected to adopt a definition provided by the Assembly of First Nations (AFN) (2010) which states:

“Although there is no universally accepted definition of ‘traditional knowledge’, the term is commonly understood to refer to collective knowledge of traditions used by Indigenous groups to sustain and adapt themselves to their environment over time. This information is passed on from one generation to the next within the Indigenous group. Such Traditional Knowledge is unique to Indigenous communities and is rooted in the rich culture of its peoples. The knowledge may be passed down in many ways, including: storytelling; ceremonies; dances; traditions; arts and crafts; ideologies; hunting &

trapping; food gathering; food preparation and storage; spirituality; beliefs; teachings; innovations; and medicines. Traditional Knowledge is usually shared among Elders, healers, or hunters and gatherers, and is passed on to the next generation through ceremonies, stories or teachings” (2).

With this definition in mind I would argue that the stories shared by the participants in this study through the form of interviews represent a form of traditional knowledge. This reasoning suggests that the information gathered throughout the interviews represents my epistemological perspective. I further add that consideration of traditional knowledge throughout the research process can ultimately help bring meaning and understanding of the health and illness experience of living with type II diabetes (Cochran et al., 2008; Durie, 2004). Western ways of knowing inform the way in which knowledge is acquired and organized by researchers and risks being culturally inappropriate (Smith, 1999). This is why I believe it is not only important but essential to consider Indigenous forms and views on knowledge.

I realize that my ontological and epistemological perspectives are primarily influenced and entrenched in or by Western ways of knowing and ideologies. I also recognize that there is a growing awareness and push to consider and accept alternate ways of knowing. These include the consideration and discovery of Aboriginal ontology and epistemology. It is important to consider that the Aboriginal culture may influence its worldviews which are unique and different from the “rational, scientific paradigm” of the Euro-western tradition or worldview (Pilkington et al., 2011; Pilkington et al., 2010; Bartlett et al., 2007; Dumont, 2005). Aboriginal definitions and conceptualizations of both culture and health that were presented earlier help to highlight some of the unique differences that exist between Aboriginal and Western worldviews and ways

of knowing. Now that I have provided some background and context outlining the differences in worldviews as well as what constitutes traditional knowledge I will now delve further into the concept of colonization and how this might have an impact on the experience of living with type II diabetes for Aboriginal peoples. This detailed review of the concept of colonization as it is related to Aboriginal peoples will ultimately help to lay the groundwork to explicate my selection of a constructivist, post-colonial, and decolonizing approach to underpin this study.

2.3 Colonization

I will now present some of the original scholars who have written extensively on the topic of colonization from their various and unique perspectives. I will begin with presenting the viewpoint of various international scholars which will be followed by the often contrasting view of noted Aboriginal scholars. It was in examining this literature that I was ultimately able to position myself in terms of how I have come to understand and define what colonization means for me and how it is operationalized in this study.

2.3.1 James Collier's Theory

More formal and academic writings on colonization date back as far as 1905 in the works of such scholars as James Collier who came up with what he framed as a theory of colonization. Throughout his description of colonialism he uses a lot of interesting yet at times paternalistic metaphors such as motherland and embryonic state in reference to conquered lands. The ultimate goal of colonialism, according to Collier, appears to be to reproduce what existed in the country of origin in the newly occupied regions of the world. With the use of a metaphor to explain colonization Collier (1905) wrote: "Once they have settled in their new environment and overcome the inevitable obstacles, it might seem, the ways of life, the institutions, the arts and

literature, and all that is characteristic of the old community, would spring up in the new as a transplanted flower or tree blossoms or fruits in new soil” (253). In this quote he appears to only be scraping the surface of the meaning of colonization. He goes on to suggest however that “when one group conquers another and reduces its numbers it will at the same time lessen the power of that group, to fill unoccupied places in nature, to create new places, and thus generate an improved species” (258).

His theory could be critiqued as being very one sided and as presenting a Pollyanna view of colonization because it fails to take into account the impact on the colonized. How could it not since he essentially represents the dominant society and those who perpetuated colonialism. His theory appears to focus on what is believed to be an opportunity for a new and improved society or way of life at the expense of and without considering the impact of those who were here first, in this case Canada’s First People. Although his ideas warrant some consideration, I believe that some of the more recent writings on the topic of colonization merit further consideration. Although I find Collier’s ideas and writing interesting I am choosing to reject his ‘theory’ and rather chose to gain a better understanding of colonization from the perspective of scholars who seem to consider this concept more broadly to include the perspective of those directly impacted by it.

2.3.2 Defining colonization

Many of the more contemporary and key authors on colonization have emerged in the 20th century and have positioned themselves in the arena of post-colonial theory which has provided important theoretical underpinnings for this study. I will briefly present the works of some of the key scholars, such as Fanon (1952), Memmi (1965) and Said (1978) as well as

Aboriginal scholars such as Alfred (2009), and Coulthard (2014) and Smith (1999) .Each of these academics has provided explanations of the concept of colonization by addressing various dimensions of the concept such as ‘the how’, ‘the what’ and ‘the who’ of colonization from their individual perspectives.

2.3.2.1 *Frantz Fanon*

Fanon (1952), a French psychiatrist’s work provides us with a glimpse into ‘the what’ or outcomes of colonization or colonial practice. In his work he suggests that the etiology of many health related problems for those who have been colonized include cultural assimilation, dehumanization, and segregation, depravity of religious freedom and loss of control over the land. Fanon’s work focused on the process of colonization and assists “in understanding how the hierarchy of the colonized/colonizer is established and held in place” (Cote-Meek, 2010, 96). His work also considers the psychological impact that colonization can have on the colonized. A lot of his work has considered the impact of the violent aspects associated with colonialism.

With respect to Aboriginal people in particular, segregation on reserves and forcefully being placed in residential schools represent two concrete examples of segregation, cultural assimilation and ultimately being deprived of religious freedom by having Christianity forced upon them. It has been well documented that violence took place especially for those who had the misfortune of being forced to attend residential schools. Although there is no direct link made between colonization and the development of chronic illness such as diabetes, it could be argued that a relationship might exist between for example, assimilation and loss of control of the land and the development of diabetes. Some of the literature presented earlier in Chapter One which discussed the impact of stress on cortisol levels and how this has been linked to the

development of diabetes seems to somehow relate to Fanon's views on violence and its impact on Aboriginal peoples. Once again his perspective might be considered limited and not entirely applicable or representative of the experience of Aboriginal peoples. What is clear however is that colonization can and has had negative impacts on those who have experienced it.

2.3.2.2 Albert Memmi

Memmi (1965) a Tunisian Jewish philosopher and teacher focused on attempting to explain or describe who the colonizer is in relation to those who have been colonized. He views the colonizer as a person who imposes his culture, a way of life that includes government, education, socioeconomic systems on another in total disregard for the other's culture. He believes that the outcome of this is that of a system that is fundamentally unstable and one that will lead to its own destruction due to its rigidity. He views colonialism as a variation of fascism based on economic privilege rather than on religious conversion and civilization which are often suggested as the ultimate goals of colonization. He further believes that racism is an ingrained and important concept which is closely linked with colonization. Memmi (1965) affirms "the colonist resorts to racism. It is significant that racism is part of colonialism throughout the world and is no coincidence. Racism sums up and symbolizes the fundamental relation which unites colonialist and colonized" (70). He believes that ultimately there are only two possible solutions, assimilation or revolution. Clearly we have seen and continue to see today evidence of both transpiring. The legacy of the government's assimilationist policies and practices remain today in the form of the Indian Act. Although the Idle no more movement, which has emerged over the last few years, may not be considered a revolution as such it could certainly be considered as the possible beginning of a renewed awareness and outcry against ongoing colonialism in Canada by

some of its Aboriginal peoples. The reasons and background for this Aboriginal up-rising of sorts was born out of the need to address the colonial past and how it has and continues to impact Canada's original inhabitants. The critical position adopted by the '*Idle no more*' movement was founded and influenced by Eurocentric and Imperialist versions of history. It represents a critique of the establishment of, among other things, reserves and the political perspective of being colonized (*Idle no More*, 2015).

2.3.2.3 Edward W. Said

Said was a Palestinian American English professor and literary theoretician who wrote the book *Orientalism*. His work provides a critical analysis of what he deems to be culturally inaccurate representations that form the bases of Orientalism. He suggests that the notions of political intellectualism, cultural discrimination and imperial domination form the core principals of imperial ideology which have resulted or translated into colonial practices throughout the world. In his words "imperialism means the practice, the theory, and the attitudes of a dominating metropolitan centre ruling a distant territory...colonialism, which is almost always a consequence of imperialism, is the implanting of settlements on distant territory" (Said, 1993, 8). For Said colonization, which requires a certain ideology, was ultimately about gaining access and control of the distant lands and their resources.

His work provides an explanation of 'the how' of colonization, which is, how it came to be or its origins. It is important to note that Said was primarily influenced by his experiences growing up in Palestine and the conflicts and war that he experienced living in the Middle East. Although he suggests that imperialism and its resulting colonization have been experienced

around the world one could argue that his perspective might be considered limited with respect to Aboriginal peoples.

An interpretation of colonization was presented in the preceding discussion from the perspective of some of the original and most learned international scholars on the topic. I will now turn to presenting the view of colonization from three renowned and learned Aboriginal scholars who have also contributed to the discourse in a meaningful and significant way.

2.3.2.4 Taiaieke Alfred

Alfred (2009) who originates from Kahnawake, a Mohawk Nation, is considered to be an influential and well respected scholar, author and journalist recognized for his passion and insight when it comes to politics and Indigenous governance. Over the years he has also been recognized as being a trusted advisor to a number of First Nations governments and organizations.

Alfred (2009) points out in his extensive study on the psychological and physical impacts of colonialism on Indigenous peoples within a Canadian context,

“...colonialism is best conceptualized as an irresistible outcome of a multigenerational and multifaceted process of forced dispossession and attempted acculturation – a disconnection from land, culture, and community – that has resulted in political chaos and social discord within First Nation communities and the collective dependency of First Nations upon the state” (p. 52).

Alfred (2009) has advanced many important notions in relation to colonization. The idea that colonization is ongoing is perhaps one of the most important. As a result of colonization he has discussed some of the various negative impacts that it has had on Aboriginal peoples’

culture. For example he has been quoted as stating “because of colonization, we were de-evolved; we lost what made us great. We lost our culture, we lost our freedom”(Alfred, 2009: 276). He has argued that, essentially, colonization has resulted in a complete change from the way Aboriginal people once lived.

Another important idea that is advanced by Alfred (1999) is the notion of colonial mentality which he suggests has resulted from ongoing colonialism. He goes on to explain that “the same set of factors that creates internalized oppression, blinding people to the true source of their pain, hostility, also allows them to accept, and even defend, their continuation of an unjust power relationship” (Alfred, 1999; 70). The idea of internalization and racism originally advanced by Fanon appear to be shared by Alfred. Similar to Memmi (1965), Alfred also appears to share his conceptualization of who the colonized person is in relation to the colonizer.

In response to the negative impacts of colonization Alfred (2009) can be seen as sharing his vision for the future in the following statement:

“There are many differences among the peoples that are indigenous to this land, yet the challenge facing all Onkwehonwe is the same: regaining freedom and becoming self-sufficient by confronting the disconnection and fear at the core of our existences under colonial domination. We are separated from the sources of our goodness and power: from each other, our cultures, and our lands. These connections must be restored.

Governmental power which is founded on fear, which is used to control and manipulate us in many ways; so, the strategy must be to confront fear and display the courage to act against and defeat the state’s power” (20).

Similar to Memmi (1965), Alfred (2009) appears to advance notions of revolution as a means for Aboriginal peoples to regain control over their own destinies. Although some might consider some of his views as militant he also advances the idea that there is a need for respecting “each other’s independence and each other’s way of life” (277).

2.3.2.5 Glen Sean Coulthard

Coulthard (2014), Yellowknives Dene, is an academic Aboriginal scholar who teaches in the First Nations Studies program at the University of British Columbia. Many of his ideas in relation to the concept of colonization, which appear to have been influenced by the works of Fanon, Memmi and Said, can be found in the following quote from his book *Red skin white mask*, a play on words from Fanon’s book, in which he states:

“A settler-colonial relationship is one characterized by a particular form of domination, that is, it is a relationship where power – in this case, interrelated discursive and non-discursive facets of economic, gendered, racial, and state power-has been structured into a relatively secure or sedimented set of hierarchal social relations that continue to facilitate the dispossession of Indigenous peoples of their lands and self-determining authority. In this respect, Canada is no different from most other settler-colonial powers: in the Canadian context, colonial domination continues to be structurally committed to maintain-through force, fraud, and more recently, so-called ‘negotiations’-ongoing state access to the land and resources that contradictorily provide the material and spiritual sustenance of Indigenous societies on the one hand, and the foundation of colonial state-formulation, settlement, and capitalist development on the other” (Coulthard, 2014:7).

In the preceding quote the link between colonization and the acquisition of land and its resources is quite evident, an idea advanced earlier by Said. Coulthard appears to contextualize this issue beyond Said's original conceptualization by applying it specifically to the Canadian context. The notion that colonialism is ongoing is also evident in his statement. The concepts of power and domination appear central to his arguments. There is evidence from his writings that he at times critiques some of his counterparts while at the same time advancing some of their key ideas as they relate to Canada's Aboriginal peoples.

In his book Coulthard (2014) also engages in a dialogue on internalization that takes place in colonized individuals not unlike many of the other scholars who have preceded him. In drawing on Fanon's work he states: "colonized populations tend to internalize the derogatory images imposed on them by their colonial 'masters' and how as a result of this process, these images, along with the structural relations in which they are entwined come to be recognized (or at least endured) as more or less natural" (32). As previously noted Alfred (1999) referred to this form of internalization as adopting a colonial mentality.

Finally, although he does not explicitly appear to be advancing the idea of revolution per se it could be argued that he is at the very least challenging the Canadian government's dealings with Aboriginal peoples as it relates to the land at least as nothing more than so-called negotiations since very little with respect to ownership of the land and its resources appears to have changed. There is certainly a suggestion that the status quo is no longer acceptable. In terms of revolution or perhaps more appropriately political activism on the part of Aboriginal peoples, Indigenous resistance movements (Coulthard, 2014) such as Idle no more which was

born in 2012 is perhaps a good contemporary example of how Aboriginal peoples are becoming more mobilized and reacting to ongoing colonialism.

2.3.2.6 *Linda Tuhiwai Smith*

Smith (1999) is described as an Indigenous scholar from New Zealand. In her well known book on decolonizing methodologies she is quite critical of the role that Western scholarly research has played in perpetuating colonialism amongst Aboriginal peoples throughout the world. Identifying as an Indigenous person she clearly identifies and positions herself as approaching her work from the point of view of the colonized. In her work Smith has highlighted the various ways in which the process of research, which has historically been carried out on Aboriginal peoples as opposed to with them, provides yet another example of how colonization can be perpetuated and remains ongoing

Much like is found in the works of Alfred and Coulthard, Smith (1999) appears to have been influenced by some of the original colonialism theorists. She also provides critiques of some of the earlier works and often makes reference to the New Zealand and Australian contexts although not at the exclusion of Aboriginal peoples in other parts of the world. In drawing on her understanding of colonization, what it is, how it operates, Smith advances the important idea of the need for a decolonized approach to conducting research with Aboriginal peoples. Her insights have had played a major role in promoting decolonizing methodologies in the arena of Aboriginal research in general and in this research project in particular.

Although she is not suggesting that non-Aboriginal scholars should avoid engaging in research in this area she has advanced and promoted the idea that there is a need for more Aboriginal researchers, which is well articulated in the following quote: “When indigenous

peoples become the researchers and not merely the researched, the activity of research is transformed” (Smith, 1999: 193). That being said she also suggests that as a result of the Western influence on the way most academics are trained, which includes Aboriginal scholars, it cannot be taken for granted that all Aboriginal researchers will “have some form of historical and critical analysis of the role of research in the indigenous world” (Smith, 1999: 5). The notion of transforming research into something that is no longer feared or questioned to something that is culturally safe and has meaning and benefit for Aboriginal peoples as articulated by Jacklin and Kinoshameg (2008) is central to Smith’s work.

2.3.3. The Eurocentric and imperialist version of history

It has been well documented that Aboriginal peoples were the original inhabitants of this land. In spite of this well-known fact many to this day continue to attest that Canada was in fact discovered by the Europeans and all that exists today has resulted from this discovery (Frideres & Gadacz, 2008). This Eurocentric and imperialistic version of history has all but negated the efforts and accomplishments of those who were here long before the white man came (Dickason, 1992). One might argue that this ultimately set the stage for what was to become conquered nation of unsuspecting and trusting people upon which foreign values, beliefs and systems were imposed. Colonization is the cause and outcome of this conquest.

The establishment of the dominant European society resulted in the marginalization of Aboriginal people. Interestingly Frideres & Gardacz (2008) suggest that there existed a difference between the French-Aboriginal and British-Aboriginal relations. The French approach was seen as less condemning and attempted to better understand the culture whereas the English approach was one of domination and claiming of the land. In spite of this

distinction both the French and English ultimately came with a goal to conquer and control. Ultimately it has been argued that French and English motivations were ultimately quite complex (Trigger, 1985).

Lands were apprehended and Aboriginal people were relegated to smaller less valuable parcels because it was felt that they were not using the land (Dickason, 1992 ; Trigger, 1985) or would not be able to do anything with the land anyway (Frolich, Ross & Richmond, 2006). This relegation ultimately led to the establishment of a culture of poverty and essentially “propelled Aboriginal people to the margins of our society” (Frideres & Gardacz, 2008: p. 7). These eventually had an impact on Aboriginal people’s ability to access and live off the land. More importantly as Durie (2004) points out “alienation of people from their environment- from the natural world-may be as closely linked to the host of health problems that beset indigenous peoples as the more familiar life-style risks of modern living” (p. 1139).

Some have used this argument to promote the end of the reserve system in favor of integration, not to be confused with assimilation, into mainstream society (Warry, 2007). For example well-known right wing neo-conservative writer Tom Flanagan has long argued for the end of the Aboriginal reserve system in favor of integration into mainstream society. In spite of Flanagan and many others like him the reserve system continues today for better or for worse. I would further add that Flanagan and some of his contemporaries motivation for promoting an end to the reserve system was certainly not to benefit Aboriginal peoples but rather to remove the burden of the government’s fiduciary responsibility to Aboriginal peoples.

By integrating Aboriginal people into mainstream society he and many others like him argue that they would become more like everyone else. Flanagan and his contemporaries refer

to this as integration but many others would argue that it is basically assimilation (Warry, 2007) or as Duncan Campbell Scott once suggested as a means of “resolving the Native issue”. The problem with this perspective is that it would ultimately ignore First Nation status and all of the distinctions, rights and entitlements which are associated it . Aboriginal peoples’ claims to the land and its resources would be negated which would ultimately pave the way for the government to obtain control and settle the dispute over land ownership once and for all. As one can see, the dismantling of the reserve system is more about benefiting the colonizer and less so the colonized who had the land and all of its resources stolen in the first place. A discussion on the history of reserves in Canada was presented since all of the participants in this study resided in First Nation communities or reserves.

The imposition of imperialist systems and ways of life ultimately led to the negation of existing social, economic, political and spiritual structures which were for the most part viewed as inferior to European ways. Evidence of these impositions are certainly present today as evidenced by the loss of important cultural assets and Indigenous knowledge such as language, traditional food ways, medicines and healing practices to name a few (Wilson, 2005).

2.3.3.1 Critics of the establishment of reserves

The establishment of reserves represents yet another example of colonization. Aboriginal people were relegated by the government to live in predetermined and well defined territories that were often remote and isolated. The establishment of reserves has led to the classifications of First Nation people as living on reserve or off reserve. The term “band” is often used to describe a group of Aboriginal people residing on one or more reserves. There were an estimated 610 bands as of 2010 and an estimated 2720 reserves in Canada with the

second highest number of these at 185 being located in Ontario (Frideres & Gadacz, 2008). Under the Indian Act, in order to be considered a “Status Indian” Aboriginal people are required to be registered as a member of one of the over 610 bands across Canada. These reserves or bands are often referred to as communities by Aboriginal peoples. The concept of community is very important especially for Aboriginal people (Frideres and Gadacz, 2008) and is often used instead of the term reserve which is a colonial outcome. I make this point because the focus of this study has been on Aboriginal peoples living in First Nation communities which does not consider the perspective of Aboriginal peoples living off reserve or in more urban areas. This distinction is important to make since it is quite evident in reviewing the literature that the challenges faced by these two groups are at times quite different and unique.

It is quite evident that colonization which dates back some time has had significant negative social, cultural, political and environmental impacts on Aboriginal people (Warry, 2007; Ferreira & Lang, 2006; Battiste, 2000; Smith, 1999; Joe & Young, 1998). The notions of dispossession, subjugation and oppression are often associated with colonization (Emberley, 2007; Ferreira & Lang, 2006; Warry, 1998; Waldram et al., Young, 1994) as is inequity which has translated into health disparities for Aboriginal people (Adelson, 2005). Aboriginal scholars such as Hingangaroa-Smith (2000) caution however that Aboriginal peoples need to be cautious about “naming” themselves since these:

(...) labels can contribute to perpetuating our subordination and may both produce and reproduce our cultural oppression and economic exploitation...labels such as “minority,” “oppressed,” “exploited,” and “subordinate” are useful when used sparingly and with critical understanding...If we spend time naming ourselves as a subordinate

group, we're in danger of entrenching, producing, and reproducing our subordination because we also, in a relativist way, are naming the "others" as the dominant group" (212).

This critical perspective on labelling as further contributing to subordination and marginalization is important to consider and perhaps needs to inform and direct the way in which these labels are applied. This represents an example of what has come to be considered as a 'colonization of the mind'. That is the historic and ongoing legacies have impacted the way Aboriginal peoples view themselves in relation to the world around them.

There are essentially two ways in which colonization is often presented in the literature. That is, from the perspective of the colonizer and from that of the colonized. It should come as no surprise that the interpretation between these two perspectives might be somewhat divergent if not often opposed. It is for that reason that I believe that it is important to consider the concept of colonialism from these two completely different perspectives.

2.3.3.2. The colonizer and the colonized

Throughout the preceding discussion as well as the one that follows, the terms colonizer and colonized are frequently encountered. I believe it is important to begin this section by providing a working definition of how these two terms are often understood and utilized in the context of colonial discourse. I will begin with the term colonizer since as Memmi (1965) points out, one cannot exist without the other and that the relationship between the two has actually "chained the colonizer and the colonized into an implacable dependence, molded their respective characters and dictated their conduct" (ix). The term colonizer is often associated with such

characteristics as privileged (Memmi, 1965) and possessing a certain ideology that is usually one of superiority (Said, 1993).

Often throughout the discourse that employs the terms colonizer and colonized there appears to be an automatic assumption that a dichotomy and hierarchy exists between the two with the colonizer as being superior to the colonized. Although a clear dichotomy often appears to exist between the colonizer and the colonized I believe that there are varying degrees of this dichotomy and it is important not to make the automatic assumption that each of these groups is homogeneous. My point is that there are many examples of who and what represents the colonizer which could include individuals, groups, and in our Canadian context often the government.

Similarly there are likely a number of ways to construct who is colonized and to what degree they have been colonized. The term colonized is often applied to individuals or groups that have been impacted, usually in a negative sense, as a result of European expansion over the last many centuries. According to Memmi (1965) the notion of being colonized is often constructed in such a way that suggests that they are inferior, subordinate and dependent on the colonizer.

One of the critiques in the literature is the notion that there exists a distinct difference between the colonized and their colonizers (Narayan, 2000; Hall 1996). I could certainly be accused of having made the same distinction earlier when I presented the different perspectives of the colonizer and the colonized. This is seen as problematic for as McConaghy (2000) writes: “It is no longer always useful to present dichotomies of the coloniser and the colonized to illustrate the differential power relations and life experiences of those in colonial contexts...An

important task is to better understand the specific nature of specific oppressions at specific sites; to understand current forms of oppression” (McConaghy, 2000: 8). We need to be careful not to make assumptions about people in terms of who they are as this could perpetuate stereotypes and racism which is what we are ultimately trying to avoid doing (Anderson, 2004).

I believe that it is important to consider the two terms in this light in order to avoid the possibility of further labeling, victimizing and even pathologizing Aboriginal peoples (Johnson, 2003). Furthermore I would add that not everyone who is non-Aboriginal would consider themselves to be a colonizer but perhaps more of an ally who is sympathetic to the impact that colonization has had on Aboriginal peoples. Similarly, not all Aboriginal peoples will necessarily consider themselves to be colonized. These two terms are labels and one has to be cautious in how they are utilized. They were presented only because they exist and to highlight some of the problematic issues that they can raise.

It is readily apparent that these two views are often quite divergent in their representations (Adelson, 2005; Hart, 2002; Smith, 1999; Kelm, 1998). The colonizer can never fully appreciate what it is like to be oppressed and considered to hold worldviews that are somehow less valuable and important than those of a Euro-centric dominant society (Hart, 2002). Consequently even though there is a general appreciation of what it must be like to be colonized any attempt at articulating this experience is limited at best and can never be achieved. One cannot fully explain something that he or she has not experienced. On the other hand those who have experienced colonization first hand may be able to more clearly articulate how what appears to be a negative experience has impacted them individually and collectively as well as at various levels such as cultural, emotional, spiritual, psychological and physical (Farmer, 2005;

Hart, 2002; Kelm, 1998). It is certainly the intention of this study to give a voice and provide an opportunity for the participants who are representatives of the colonized minority to share their perspectives in particular as it relates to their experiences of living with type II diabetes.

2.3.3.3 The political perspective of being colonized

The concepts of power and strength are often used in articulating the experience of being colonized. Kelm (1998) provides a clear example of how Aboriginal peoples experienced colonization through the loss of basic rights such as hunting and fishing. When the colonizers came and restricted Aboriginal people's rights to hunt and fish they were essentially impacting self-determination, traditional subsistence and economy. It is not exactly clear what impact this loss of control over the land has had on the health and illness experience of Aboriginal people. It has however been suggested that connection to and access to the land have been impacted to the point where there is certainly less reliance on traditional ways of living and more so on introduced Western ways when it comes to sustenance and medicine (Earle, 2011).

Although the concept of colonization has been introduced it is equally important to further elaborate on how this term will be operationalized. Various dimensions of colonization exist such as political, social, economic, psychological, and cultural (Waldram et al, 2007; Smith, 1999). For the purposes of this study the emphasis will be placed on the socio-political and cultural impact of colonization as these relate to the self-management of type II diabetes. Through the experience of living with type II diabetes this study will attempt to uncover how colonialism impacts the way in which Aboriginal people experience and perceive how they have come to develop type II diabetes and how this is constructed. To that end I believe it is

important to demonstrate how the political impact has perhaps had the ultimate impact on all of these other perspectives.

Colonization is the outcome of centuries of oppression and marginalization of Aboriginal people by first the European settlers and now by contemporary governments (Fanon, 1952; Memmi, 1965; Said, 1978; Smith, 1999). Colonization has resulted in the degradation of the land by corporate industries, dislocation of Aboriginal peoples from their traditional lands, and racist government policies have forced assimilation of Aboriginal peoples within the dominant culture (Raphael, 2009; Waldram et al., 2007). Being forced to attend residential school, which resulted in being removed from one's culture and ways of being, doing and eating, all represent the negative outcomes of European contact and domination. It has been suggested by many authors that the long lasting impact of colonization on Aboriginal peoples has ultimately translated into the development of higher rates of chronic illness including diabetes and problems with mental health, than rates found in the general population (Dumont-Smith, 2005; Health Canada, 2000; Kue Young et al., 2000; Reading, 2009; Rock, 2003; Smylie & Anderson, 2006; Waldram et al., 2007).

I believe it is important to declare that I have adopted the view that colonization, which is the outcome of imperial ideology, is still ongoing today. Colonization should not be understood as a temporal concept that suggests that colonialism no longer exists but rather as a way of critically explaining the ways in which colonialism has impacted Aboriginal Peoples in the past and how it continues to do so today (Cote-Meek, 2010; Said, 1978). Given the obvious negative past and ongoing impacts of colonization on Aboriginal peoples it seems only logical that one consider how this outcome of European hegemony might possibly be addressed.

In this section I provided an extensive review and critique of the concept of colonization. The intent was to clearly articulate how colonialism originated, how it has impacted Aboriginal peoples in particular, and some of the negative outcomes such as loss of Indigenous knowledge such as language, traditions, healing practices and ways of accessing and living off the land. It was also important to demonstrate how a link has been made between the impact of colonization and the development of type II diabetes in particular. My goal was also to lay the groundwork for why I have elected to underpin my study with a postcolonial theoretical framework.

2.4 Theoretical Framework

I will now provide an explanation of why I have selected a constructivist philosophical stance guided by theories of post-colonialism and decolonization. I will then follow this by providing an outline of the conceptual framework consisting of a decolonized model of diabetes care for Aboriginal peoples which developed over the course of my inductive reasoning and has ultimately guided every aspect of my research journey from beginning to end.

2.4.1 Postcolonial theory

Postcolonial theory has provided a theoretical framework for this study and can be “best conceptualized as a family of theories sharing a social, political, and moral concern about the history and legacy of colonialism-how it continues to shape people’s lives, well-being, and life opportunities” (Browne & Smye & Varcoe, 2005: 19). It has interdisciplinary roots and was advanced by various disciplines such as cultural studies, political science, literary criticism, and sociology. All of these disciplines appear to come to a sort of agreement on some of the theory’s

key points such as: i) not losing sight of the impact and ongoing legacy of colonization; ii) considering and being critical of the experience of colonization; iii) promoting that the perspective of the colonized be considered above that of the dominant culture; and iv) expanding the understanding of how race, racialization, and culture are conceptualized in past and present ‘post-colonial’ contexts (Browne & Smye & Varcoe, 2005). A number of scholars such as Bhabha (1994), Gandhi (1998), Hall (1996), and Said (1978), have contributed to the advancement of this theory. Simply stated, postcolonial theory provides a way of dealing with the effects of colonization on different cultures and societies (Ashcroft, Griffiths, & Tiffin, 2007).

There are also various concepts associated within postcolonial dialogue with race, racialization, culture and ‘Othering’ being seen as most closely relevant to health and health care (Anderson, 2004). According to Anderson (2004), the concept of race is quite significant and postcolonial theory

“...focuses our attention on the process of dehumanization and human suffering throughout history, and gives us a context for understanding health inequalities. It brings to the forefront the issue of ‘race’ and makes explicit how this socially constructed category has been used in the colonizing process, and the effect that this has had on peoples’ lives and life opportunities” (240).

While the concepts of race and racialization are perhaps better understood I think it is important to take a moment to address the concept of ‘Othering’. According to Brown, Smye, and Varcoe (2005) Othering “refers to the projection of assumed cultural characteristics, “differences”, or identities onto members of particular groups. Such projecting is not based on

actual identities; rather, it is founded on stereotyped identities. In the recent past, for instance, residential schooling was enforced as a means of what some advanced as the need to preserve the health of Aboriginal children who required protection from their ‘negligent and ignorant’ parents” (Brown, Smye, & Varcoe, 2005: 21) however it has been well documented that it was more about assimilation (Waldram, Herring, & Young, 2007). These negative stereotypes abound and are firmly entrenched into the beliefs of many Canadians. Notions such as poverty, substance abuse and dependency to name a few represent examples of such racialized beliefs (Furniss, 1999). These concepts are important to present since most if not all of these will be addressed in some form or other within this work.

The suggestion of ‘post’ in relation to postcolonial can be seen as problematic and even misleading by some. It has generated some debate at times suggesting that perhaps since colonialism is ongoing to suggest there exists a postcolonial era is inappropriate (Smith, 1999; Hall, 1996). For example Smith (1999) rejects the term post-colonialism and asserts “to name the world as postcolonial is, from indigenous perspectives, to name colonialism as finished business... There is rather compelling evidence that in fact this has not occurred...the institutions and legacy of colonialism have remained” (Smith, 1999: 98). In her book on decolonizing methodologies Smith (1999) focuses the first part on critiquing the dominant Western ways of doing research and all of the associated assumptions and the second half of the book is dedicated to promoting a decolonizing approach to conducting research with Indigenous peoples. Although her book appears to be targeting primarily Indigenous scholars and research it does have application for non-Indigenous researchers as well. Similarly Hingangaroa (2000) affirms that there currently exist “new forms of colonization” and that he does “not believe for

an instant that we are in a postcolonial period” (Hingangaroa, 2000: 215). Instead he has suggested that the term ‘anti-colonial’ should be used “to describe the proactive position of resistance that Indigenous peoples should adopt to these neo-colonial formations” (Hingangaroa, 2000: p. 215). Some would argue that post colonialism should not be viewed as a temporal concept signaling the end of colonialism but that “post-colonialism is, rather, an engagement with, and contestation of, colonialism's discourses, power structures, and social hierarchies. . . . A theory of post-colonialism must, then, respond to more than the merely chronological construction of post-independence, and to more than just the discursive experience of imperialism” (Gilbert, Helen; Tompkins, Joanne, 1996:110). It is in this spirit in which I have elected to view postcolonial theory, that is, as a means to critically examine the historical and contemporary impact of colonization especially in the context of type II diabetes. By adopting this position I am not suggesting that colonialism has ceased or that ‘new forms of colonization’ have not taken its place. I am suggesting rather that the notion of moving beyond a colonial era is required and essential.

Post-modern thinking such as postcolonialism can be viewed as a form of critical and ‘anti-oppressive’ theory that challenges the positivist assumptions about reality in favor of promoting the idea that “social reality cannot be described or explained with certainty or in authoritarian terms” (Brown & Strega, 2005). In other words it is complex and subjective in nature.

2.4.2 Critiques and limitations of postcolonial theory

This theory is not without its critics and limitations (Alfred, 2009; Brown, Smye, & Varcoe, 2005; LaRocque, 1996,; Battiste, 2000). It has suggested that “ while postcolonial

discourses offer a powerful set of analytical tools, researchers must engage critically with postcolonial theories and scrutinize what some might consider an imposition of Eurocentric theory onto issues of importance to Aboriginal peoples” (Browne, Smye, & Varcoe, 2005: 22). Since postcolonial theory was born out of Western philosophy it is essential that any of its potential shortcomings be considered. This later position is essentially at the heart of Smith’s (1999) argument that postcolonialism should be rejected. I believe it is important to now more critically examine postcolonial theory by examining some of the recommendations that have been made by Aboriginal scholars.

It is perhaps necessary to point out that most of the scholars who have been referenced thus far, with the exception of Smith (1999) in relation to postcolonial theory are in fact non-Aboriginal. This is not to say that Aboriginal scholars have not been involved in this discourse. For example Alfred (2009) a Mohawk scholar and author, LaRocque (1996) a Metis scholar and Battiste (2000) a Mi’kmaq educator from Nova Scotia have contributed in a significant manner not only to the discourse on postcolonial theory but perhaps more importantly in the area of postcolonial Indigenous knowledge as a means to inform postcolonial theories (Browne, Smye, & Varcoe, 2005). Battiste (2000) points out about postcolonial theory and Indigenous knowledge that “ although they are related endeavors, postcolonial Indigenous thought also emerges from the inability of Eurocentric theory to deal with the complexities of colonialism and its assumptions” (Battiste, 2002: xix). These two perspectives have differing epistemologies on sources or ways of gaining knowledge.

In his book *Wasase* Alfred (2009) points out that the notion of reconciliation, which has emerged during this so-called post-colonial period, is problematic and not very compelling and

goes so far as to refer to it as an “emasculating concept” (152). He argues that without restitution of lands and adequate financial transfers aimed at compensating “for past harms and continuing injustices” there can be no reconciliation (152). Therefore it could be argued that post-colonialism cannot exist until such a time as full restitution to Aboriginal peoples has taken place.

Postcolonial theory was born out of Western ways of thinking while postcolonial Indigenous knowledge is concerned with Aboriginal ways of knowing, worldviews and how to conduct research that subscribes to Aboriginal principles, values and beliefs. The importance of learning from experiences and storytelling are classic examples of Aboriginal epistemology (Brown & Strega, 2005). Consequently it has been suggested that “Indigenous knowledge can (and should) be used to inform postcolonial theories” (Browne, Smye, & Varcoe, 2005, 23).

In keeping with one of the principles of decolonization, giving Indigenous knowledge a more prominent position and consideration can, as these Aboriginal scholars have pointed out, address some of the Eurocentric limitations likely to be inherent in postcolonial theory given its Western origins. As Wilson (2005) points out

“reclamation of indigenous knowledge is more than resistance to colonial domination; it is also a signifier of cultural revitalization and mounting Native nationalism. While the hard work of our internal decolonization remains a project that must be taken up by people in our communities, indigenous scholars have the opportunity an obligation to utilize our research, analysis, writing, and teaching skills to facilitate that process in whatever way we can. Ultimately, the strength of our indigenous cultures rests on our ability to exert our humanity through the decolonization of our minds and the

transformation of the world around us while recognizing that our truths stem from the eternal nature of our languages, ceremonies, worldviews, and values” (Wilson, 2005: 262).

Another critique is that at times postcolonial discourse can suggest, for example, that all Aboriginal peoples share the same experience when it comes to colonization (Gandhi, 1998). To make such a suggestion does not seem rational when adopting the ontological position that reality is created and is likely to vary from one individual to the next. By painting everyone with the same brush we are not able to capture individual experiences and perspectives. Aboriginal peoples are not homogenous and represent many nations of peoples with different cultures, languages, values and beliefs. It is therefore important to avoid making such assumptions when underpinning a study with postcolonial theory.

Brown and colleagues (2005) believe that post colonialism has tended to focus more on race, ethnicity and culture and less so on gender and class. To address this they have suggested including feminist theory in order to prevent overlooking the importance or role that gender or perhaps even class might play in any given context. Although not explicitly stated it might be safe to assume that to some extent feminist theory has also informed and influenced the way in which postcolonial theory is being considered for this study. I would further argue given the differences in gender roles as it relates to Aboriginal culture and peoples it would be very difficult if not impossible not to consider the role and importance that gender has when it comes to living with type II diabetes.

In the words of Gandhi (1998) and in spite of its many critics and limitations “post colonialism also holds out the possibility of thinking our way through, and therefore, out of the

historical imbalances and cultural inequalities produced by the colonial encounter. And in its best moments has supplied the academic world with an ethical paradigm for a systematic critique of institutional suffering” (Ghandi, 1998: 176). It is my contention that this theory provides a suitable methodological and analytic framework which will help to better understand and bring meaning to the complexities of colonization and decolonization as they relate to type II diabetes. In order to achieve this I have constructed a conceptual framework that is made up of key concepts that have evolved from my extensive review of the literature on the topic of colonization and type II diabetes in Aboriginal peoples.

2.5 Conceptual framework

In the preceding section I presented a postcolonial theoretical framework which has served to underpin my exploration of the phenomenon of Aboriginal peoples living with type II diabetes. The selection of this theoretical stance was strongly influenced by the historical and ongoing legacy of colonization. Some important and related concepts eventually emerged as a result of the review of the theoretical and empirical literature. These concepts have ultimately helped me to develop a conceptual framework that has assisted with the research design, informed the methodology and methods, as well as provided direction throughout the analysis of the data.

Jabareen (2009) defines a “conceptual framework as a network, or “a plane”, of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena” (Jabareen, 2009: 51). These concepts are not to be considered in isolation but rather in relation to one another in order to provide a method of interpreting or better understanding a ‘social reality’ or phenomenon such as type II diabetes (Miles & Huberman,

1994). The concept of diabetes has been explored and conceptualized in the preceding sections. It is understood that all of the key concepts associated with this study are being considered in the context of type II diabetes. In addition, the concepts of culture, cultural safety, health, self-determination, and finally decolonization. Although each concept will be presented separately the concept of decolonization is considered to be a particularly important element of this conceptual framework. I will now present each concept individually beginning with culture which will be followed by an explanation of how they are linked.

2.5.1 *Culture*

The influence of culture is a significant factor to be considered especially since this study is exploring the experiences of Aboriginal people who live with type II diabetes and have been impacted by colonization. It is important to consider what culture is and how is it defined, understood and conceptualized. This question was put to the participants in this study in order to gain a better understanding of what culture meant for them and how this was represented. In the following section I will briefly present the concept of culture in its broadest sense and then focus on some of the particularities of Aboriginal culture.

Helman (2000), a medical anthropologist, suggests that:

(...) culture is a set of guidelines (both explicit and implicit) that individuals inherit as members of a particular society, that tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation-by the use of symbols, language, art and rituals. To some extent, culture can be seen as an inherited 'lens'

through which the individual perceives and understands the world that he inhabits and learns how to live within it” (2).

On its surface this definition could be seen as being quite inclusive and applicable to the vast majority. I would argue however, from an Aboriginal perspective, that it does not take into account the historical and ongoing impact of European colonization . I would further argue that this definition fails to consider that culture is in fact dynamic and forever changing. As Helman (2000) suggests “cultures are never static: they are usually influenced by other human groups around them, and in most parts of the world they are in a constant process of adaptation and change” (3). It goes without question that colonial impact has had a significant impact on Aboriginal culture. Warry (2006) further adds that “to understand the difference between a view of culture as static and a view of culture as fluid is to take the first step to understanding Aboriginal People...Traditions change, but culture endures.” (102). Weaver (1990) an anthropologist also shared this view when she suggested that Aboriginal peoples are continuously adapting to their natural, social and political environments which has translated into the diversity in culture that is observed today. In other words just because European contact has influenced and in some ways changed Aboriginal culture from what it once was this does not mean that culture ceases to exist but rather is just different.

To suggest that Aboriginal culture could ever return to what it once was is unrealistic. Rather I choose to view culture in a less static manner and suggest that Aboriginal culture is what is occurring today and not what was done in the past. Therefore culture is quite subjective and varied. There is no right or wrong way for individual Aboriginal peoples to view culture.

Even though certain groups might share common beliefs, culture can ultimately mean something different for everyone.

More specifically the impact that colonialism has had on the disruption and erosion of Aboriginal culture must be explored when considering culture as a determinant in Aboriginal health and health care. Loss of language, traditions, access to the land, and residential school attendance all represent examples of the impact of colonialism on the culture. For Aboriginal people the discussion needs to move beyond simply defining what culture means to understanding what cultural identity actually means.

Berry (1999) has suggested that cultural identity is complex and comprised of a number of interrelated features that ultimately culminate in either a positive or negative Aboriginal cultural identity. It could therefore be argued that Aboriginal peoples who have a negative view of their traditional culture are less likely to appreciate the importance or even relevance of culture. It could further be argued that the degree to which any given Aboriginal person has been disrupted in terms of their traditional culture likely influences how they view themselves and their traditional culture. Negative experiences from attending Indian Residential Schools are often cited in the literature as reasons why some Aboriginal peoples may have taken a negative view of their culture and why in some cases may appear to be rejecting it altogether (Kelm, 1998; Warry, 2007; Truth and Reconciliation Commission, 2015). Since the notion of culture is important in this study I felt it important to lay some groundwork in order to help explain what culture is and how it might be valued or perhaps even disregarded from the perspective of Aboriginal peoples.

The connection between culture and health is also important to consider (National Collaborating Centre for Aboriginal Health, 2010). The concepts of health and illness are said to be culturally constructed (Helman, 2000; Kleinman, 1988). This particular study will be exploring the diabetes experience for a group of Aboriginal peoples living along the North Shore of Lake Huron. It could be argued that cultural differences likely exist from one group to another however, for Aboriginal peoples in Canada, most share in the historical and ongoing legacies of colonialism in one way or another (National Collaborating Centre for Aboriginal Health, 2010). Smye & Browne (2002) have argued that “from a post-colonial perspective, examining issues of health and health care within the context of culture requires a certain conceptualization of culture” (45).

The way in which various cultures maintain well-being and some of the traditional methods they employ to deal with illness can be found within “social networks” and “institutional structures” (Turton, 1997). Although cultural groups tend to share some common elements with respect to health and well-being one can also expect that variation will exist even within and amongst these cultural groups (Kleinman, 1988).

Waldram (2009) has suggested that anthropologists have struggled to understand what culture is and how it should be understood and studied. He goes on to present a simplistic view of culture that has been advanced by a number of disciplines which views Aboriginal cultures as “bounded, isolated constellations of well-defined traits, that a culture could be reasonably be seen, and studied, as though the whole were the sum of its parts, and that cultures were at once biological and sociological phenomena” (57). The problem with this definition as he points out is that this simplistic definition fails to address the ‘who’ and the ‘what’ of being Aboriginal.

This suggests that the concept of culture is quite complex, not easily defined, and likely has various meanings and conceptualizations.

2.5.2 Cultural safety

As an extension on the discussion of the concept of culture the issue of safety when it comes to culture is also important to consider. Research in the area of cultural safety appears to have originated in the healthcare literature of New Zealand (Smye & Browne, 2002), Specifically this concept appears to have originated within a nursing education context and as a result of an awareness the problem of colonization (Ramsden, 1992, 1993). More specifically it was originally conceptualized by Maori nurse leaders and educators and appears to be positioned within the arena of critical inquiry and post-colonial theory (Browne, Varcoe, Reimer-Kirkham, Lynam, & Wong, 2009). I believe it is important to point this out the concept appears to have originated from the perspective of Aboriginal peoples themselves. It was observed that Aboriginal peoples' beliefs about health and illness were often being overlooked in favor of the "dominant white culture in the construction of the healthcare system" (Smye & Browne, 2002, 46). In other words there appeared to be a lack of respect for the way in which Aboriginal peoples viewed and perhaps addressed illness and health.

One definition of the concept which has been proposed is that it "involves the recognition of the social, economic and political position of certain groups within society...aims to counter tendencies in health care that create cultural risk...reminds us that is it incumbent on all of us in health care to reflect upon the ways in which our policies, research and practices may recreate traumas inflicted upon Aboriginal people..." (Smye & Browne, 2002: 46). This broad definition contains several key points. At its core it would appear that it

has a lot to do with the way in which Aboriginal peoples are viewed and treated especially as it relates to the delivery of health care. This concept was intended to ultimately consider and address complex power relationships that can exist between Aboriginal peoples and health care providers (Ramsden, 2000).

The promotion of cultural safety was advanced as a means of raising awareness of how certain policies and practices might only serve to perpetuate trauma on Aboriginal peoples and to serve as a reminder that this practice should be critically examined. The concept of cultural safety was viewed more as “interpretive lens” rather than an entity in and of itself (Smye & Browne, 2002, 47). More recently Browne and colleagues (2009) elaborated to the conceptualization by including the idea that cultural safety can also help to “foster a focus on power imbalances and inequitable social relationships in health care; the interrelated problems of culturalism and racialization; and a commitment to social justice as central to the social mandate of nursing”(167). These conceptualizations are important to present since they help to explain how the cultural safety has been conceptualized and applied in this particular study. Since the work on this concept originated in the discipline of nursing and since I myself am a nurse I have elected to operationalize the concept from the nursing perspective.

Not unlike the concept of culture itself which is quite complex and subject to interpretation, cultural safety must also be viewed in a critical manner. Browne and colleagues (2009) have cautioned that there is a potential of “objectifying people who are already vulnerable” and “can convey that the safety to be ensured is that of the ‘cultural Other’, at once further entrenching notions on differences, focusing on individual preferences and turning attention away from the importance of reflexivity” (174). Therefore it is critical to ensure that ‘othering’ does not take

place. This can be accomplished by not losing sight of the meaning and intent of the idea of promoting cultural safety.

2.5.3 Health

The concept of health can be considered from an interdisciplinary perspective and is quite complex and broad. I believe that the way in which the concept is understood and even utilized is socially constructed and can vary from one individual to the next and from one culture to the next (Helman, 2000; Kleinman, 1988). The simplest understanding of health for many would be to be free from illness. This understanding certainly focuses on the biomedical aspect of health. I underline the word simple since I believe that health is not that simple and should be viewed in a broader and more holistic manner.

In 1948 the World Health Organization (WHO) came up with the following definition: “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Recently some have argued that the WHO definition is too vague and limited and proposed a broader and more holistic definition which should also consider “people centeredness, equity, efficiency, sustainability, community engagement, social justice, prevention, solidarity, cross-sectoral early intervention and economic and social productivity” (McPherson, 2012, 151). The definition of health was broadened in the 1978 Declaration of Alma-Ata. Similarly Waldram, Herring, & Young (2006) have suggested that “health is multidimensional and is the product of a complex interplay of biological, behavioral, environmental, socio-economic, and cultural factors” (Waldram, Herring, & Young, 2006, 125). Clearly it is important to focus beyond the physical or biomedical perspectives which are often the main focus of research when it comes to health.

Although there are likely to be similarities in the way in which non-Aboriginal and Aboriginal peoples view and conceptualize health, there are also important fundamental differences that exist. Perhaps the most important distinction is that unlike the Western biomedical model which tends to consider the body, mind and culture as being separate, Aboriginal conceptualizations of health tend to be more holistic, and are centred on living in balance and consider the link between individuals, communities and their environment (Manitowabi & Shawande, 2011; Ross, 2014). According to Malloch (1989) “a good life or good health is perceived to be a balance of physical, mental, emotional, and spiritual elements. All four interact together to form a strong, healthy person. If we neglect one of these elements we get out of balance and our health suffers in all areas” (106). The connection and interplay between these elements is important because focusing only on the physical as such tends to be the biomedical approach could lead to an imbalanced life.

During an international consultation on the health of Indigenous peoples held in Geneva in 1999, a link between culture, the environment, human rights and health were considered and the following definition of health was conceived:

“Indigenous Peoples” concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously” (Durie, 2004, 1140).

This definition is particularly important since it considers the legacies of the colonial past and how it continues and will continue to impact the health of Aboriginal peoples. The point of this definition is that a holistic definition of health for Aboriginal peoples should consider the past, present and future.

One way in which the notion of balance in the four dimensions of being is exemplified is through the use of the Medicine Wheel an important and well known teaching tool for some Aboriginal peoples (Manitowabi & Shawande, 2011). The medicine wheel is considered holistic and addresses the mental, emotional, social, as well as physical aspects of health. This model focuses on the importance of balance in all four previously mentioned areas suggesting that a lack of balance in any of the four dimensions can lead to symptoms and illness which will ultimately impact quality of life (Montour, 2000). This tool is quite complex and a more detailed explanation is beyond the scope of this discussion. Suffice it to say that its significance and importance for some Aboriginal peoples as it relates to understanding and experiencing health merit its mention and is often cited in the Aboriginal health literature.

A link exists between culture and health as well as differences in the way in which health is understood and conceptualized. Illich (1995) has suggested that: “each culture gives shape to a unique Gestalt of health and to a unique confrontation of attitudes toward pain, disease, impairment, and death, each of which designates a class of that human performance that has traditionally been called the art of suffering” (Illich, 1995: 128).

2.5.4 Self-determination

The concept of self-determination will be frequently encountered throughout this thesis. It is one of the key elements of decolonization (Wilson & Yellow Bird, 2005; Waziyatawin &

Yellow Bird, 2012), Reading & Wien (2009) suggest self-determination is the most important determinant of health for Aboriginal peoples and that it “influences all other determinants including education, housing, safety, and health opportunities” (23). A key and underlying principle of self-determination is the need for Aboriginal peoples to be equal participants when it comes to policies especially those which deal with control over lands, education, and health and social services. As a result of ongoing colonialism it has been argued that this has not been the case (Alfred, 2009; Smith, 1999). That is for the most part Aboriginal are perhaps not as involved in decision making when it comes to health among others.

The notions of resurgence and self-government are also key elements of self-determination. For Corntassell (2012) “both decolonization and resurgence facilitate a renewal of our roles and responsibilities as Indigenous peoples to the sustainable praxis of Indigenous livelihoods, food security, community governance, and relationships to the natural world and ceremonial life that enables the transmission of these cultural practices to future generations” (98). Clearly there is an important role for Aboriginal peoples to play in determining their futures socially, economically, culturally, physically but perhaps most importantly, politically. In returning to the previous discussion on the concept of cultural safety, one can readily appreciate that overlap exists between these two concepts. Specifically in order for either to be realized, Aboriginal peoples need to have more control over their destinies.

Although I am focussing on self-determination in the context of health it is important to point out that I appreciate that without self-government and more control of socio-political outcomes, the notion of self-determination could be difficult if not impossible to achieve.

Operating on the assumption that Aboriginal peoples will one day have more control over every aspect of their lives, I believe self-determination is in fact possible.

There are many ways of interpreting and attempting to understand some of the complex concepts that were presented above and that will be revisited throughout this thesis. In order to explore the question of how colonization has impacted Aboriginal peoples living with type II diabetes I felt it necessary to briefly present these key concepts by pointing out some of the differences that exist between Aboriginal and non-Aboriginal views.

2.5.5 Decolonization

There are some key principles associated with decolonization including undoing colonialism, acquisition of political or economic independence (Smith, 1999), removal of negative colonial effects (Waziyatawin-Wilson, & Yellow Bird, 2005), and perhaps most importantly, allowance of self-determination (Waziyatawin & Yellow Bird, 2012) which was presented above. Smith (1999) suggests that decolonization is a process that “engages with imperialism and colonialism at multiple levels” (20). Waziyatawin-Wilson & Yellow Bird (2005) further suggest that decolonization needs to occur in the mind of the colonized which is an idea borrowed from Memmi (1965) who wrote “In order for the colonizer to be complete master, it is not enough for him to be so in actual fact, he must also believe in its legitimacy. In order for that legitimacy to be complete, it is not enough for the colonized to be a slave, he must also accept his role” (Waziyatawin-Wilson & Yellow Bird, 2005: 88-89).

Therefore, it is my contention that decolonization is a process that is first and foremost initiated by the colonized. That being said I also believe it is important not only for the colonizer to be aware of the importance and process of decolonization but to also become a

champion of the cause and strive for decolonization as well. For the purposes of this discussion the term colonizer does not refer to any one group or agency but rather can include individuals, groups or agencies such as the Canadian government who are often in a position of power or control over others which often results in oppression and the creation of disparities and inequities in areas such as health (Memmi, 1965; Battiste, 2000; McGibbon, 2012).

Laenui (2000) has proposed that the process of colonization has five steps and that there are also five distinct phases of people's decolonization which include: rediscovery and recovery; mourning; dreaming; commitment; and action. It has, however, been argued that this type of focus is reactionary and one that places the colonizer at the centre instead of concentrating on what Aboriginal peoples actually want (Hingangaroa-Smith, 2000). This very important concept informs my theoretical framework and is integral to my conceptual framework and will be addressed in greater detail in Chapter two.

There are various ways of understanding this concept. For the purposes of this study I am choosing to consider decolonization as a both a social and political process (Battiste, 2000). Some authors such as Laenui (2000) argue that it is more social than political however it is my contention that these are not mutually exclusive and that one cannot necessarily exist without the other. In reviewing the literature it becomes evident that this important concept has been considered from various perspectives including but not limited to research, diet, health, and education (Smith, 1999; Battiste, 2000; Cote-Meek, 2010; Waziyatawin & Yellow Bird, 2012). For the purposes of this discussion and since my focus is on conducting research in the area of type II diabetes in Aboriginal peoples I will focus on the relationship between decolonization and research as well as with respect to health and diet.

Decolonization and decolonizing approaches are becoming more and more important and present in light of ongoing colonialism. Consequently I believe it is important to consider my research question through a decolonizing lens. Decolonization theory has been an integral part of my conceptual framework which has ultimately informed my research methodology and the way in which I analyzed the data. That is, the underlying principles often associated with decolonization such as striving for self-determination and the removal of negative colonial effects must be considered and applied throughout the this entire research process from the beginning and to the very end at which time the conclusions and recommendations will be presented.

As mentioned earlier, the fact that colonialism is not only a historical fact but also an ongoing reality is important to mention since these will ultimately impact not only how decolonization is understood but also how it can be considered and implemented. I believe it is important not only to be aware of this important fact but do everything possible to ensure that it can be realized. As Laenui (2000) points out: “The process of colonization and decolonization deserves closer consideration in attempting to refashion societies. Otherwise, we may find that we are merely entrenching ourselves deeper in systems, values, and controls put in place by the colonizer” (Laenui, 2000: 159). In other words continuing just as is the reality today, to perpetuate the colonial legacy.

Many scholars have begun to explore and write about what is commonly referred to as the idea of decolonization in an attempt to address the negative impact and resulting disparities for Aboriginal people (Battiste, 2000; Emberley, 2007; Maar et al., 2011; Martin & Mirraboopa, 2003; Prior, 2007; Smith, 1999; Smith et al., 2008; Smylie & Anderson, 2006;

Wilson, 2008). This discourse has significantly informed this study. The overarching message from these authors is that the practice of research as previously conducted with respect to Aboriginal peoples is inappropriate and highly problematic since it tended to be done on as opposed to with Aboriginal peoples themselves.

This awareness has resulted in a paradigm shift that is seeing a move away from traditional ways of conducting research to one that considers the impact of colonization by being more inclusive and aware of the importance of involving and even promoting that Aboriginal peoples lead the process from the beginning whenever possible (Jacklin & Warry, 2012; Minkler & Wallerstein, 2008). Some have considered methods such as decolonization as a movement towards “emancipatory research” which ultimately “seeks to counter the epistemic privilege of the scientific paradigm” which is often viewed as superior but problematic when applied to the marginalized (Brown & Strega, 2005, p. 21).

Ultimately a decolonizing approach is considered to be more culturally appropriate and relevant (Battiste, 2008; Jacklin & Warry, 2012; Smith, 1999). This type of approach considers Aboriginal approaches to health and healing (Mundel & Chapman, 2010). Specifically the idea of conducting research with Aboriginal people with the goal of discovering something that is not only useful but relevant to their context is central to decolonized methodologies (Jacklin & Kinoshameg, 2008; Maar et al., 2011). The conscious effort to conduct this particular study in a decolonizing manner and how this was integral to the design and methodology will be further explored and demonstrated.

While much emphasis has been placed on the importance of considering decolonization in the context of the research process itself, it is also important to consider the idea of

decolonization in relation to the delivery of health care especially as they relate to type II diabetes.

2.5.5.1 Practice of decolonization in promoting better health

The practice of decolonization should be considered from two different viewpoints: emic (insider) perspective; and etic (outsider) perspective. The concept of decolonizing the mind is often found in the literature with respect to addressing this concept from the emic perspective. In this case I will focus more on the approaches to decolonizing from the etic perspective.

With respect to health care in general and diabetes care in particular, decolonization is an important concept to consider because in order for health to be improved for Aboriginal peoples, who, appear to suffer disproportionately from type II diabetes, many authors and researchers have suggested that “self-determination is the cornerstone of sustainable progress toward improved health, economic and social conditions among indigenous people” (Smith, Edwards, Martens, Varcoe, & Davies, 2008: 5). Operating on the assumption that colonialism is ongoing and impacting the delivery of health care for Aboriginal peoples, it can be suggested that self-determination and perhaps even more control in how health care is accessed and delivered for and by Aboriginal peoples does not currently exist in every health care context. Certainly with initiatives such as the Aboriginal Healing and Wellness strategy and health transfer agreements to many First Nations, at least in Ontario, there has been improvement in the area of self-determination when it comes to some health services on reserves. One can therefore hypothesize that this lack of input by Aboriginal peoples in diabetes care is likely to be problematic. Therefore the notion of decolonization with respect to diabetes health care and

services is essential and needs to not only be considered but ultimately achieved. The way in which diabetes is understood, from the perspective of Aboriginal peoples must also be considered from a decolonized perspective. I propose that decolonization can be conceptualized as an internalized social and political process that focuses on self-determination with a goal of reconnecting to one's culture and in this case with the land.

The proposed conceptual framework has been developed with a goal of gaining a better understanding of the experience of living with type II diabetes for Aboriginal peoples who have been colonized. No one can really be certain just how effective the current approach or model of care for type II diabetes in Aboriginal peoples truly is. Many of my colleagues do not seem to understand or even appreciate the importance of the socio political dimension of this illness and tend to be mostly pre-occupied with treating it. This has left me to question what a truly decolonized model of diabetes care might look like.

Diabetes is often conceptualized as a genetic or hereditary illness that requires the individual to have to make significant lifestyle changes while facing the certain likelihood of developing serious if not life threatening complications. This conceptualization could be seen as quite generic and could be applied to just about anyone with type II diabetes. What this definition or conceptualization fails to consider is the reality or experience of Aboriginal peoples who have been colonized. The conceptual framework consisting of the interrelated concepts of Aboriginal peoples, type II diabetes, and decolonization may provide a decolonizing way of considering how Aboriginal peoples view and live with type II diabetes. Each concept is important to consider not only individually but how they are intricately connected one to the other.

Ultimately the goal of decolonization is “to overcome some of the long term effects of colonization” (Guerin, 2010: 61). Specifically it could address issues of inequality, marginalization, and racism to name a few. All of these impact the way in which Aboriginal peoples experience type II diabetes. As Laenui (2000) has suggested *“the process of colonization and decolonization deserves a closer consideration in attempt to refashion societies. Otherwise, we may find that we are merely entrenching ourselves deeper in the systems, values, and controls put in place by the colonizer”* (Laenui, 2000: 159).

In applying this logic to type II diabetes care for Aboriginal peoples, it could therefore be argued that if we do not consider a way to ‘decolonize diabetes’ care we will not be able to change the Western biomedical approach which is seen as problematic when it comes to providing care for Aboriginal peoples. Promoting a decolonized approach to type II diabetes care amongst health care providers may serve to empower Aboriginal peoples to consider their illness more holistically which extends beyond the biomedical and promote Aboriginal ways of knowing and doing. Essential elements of a decolonized approach might include the need to be aware of and address historical and existing power imbalances within the health care delivery context as well as the need for a culturally safe approach.

2.6 Summary

This chapter provided a detailed description of the concept of colonization and went on to explain the theoretical underpinnings of this study which was influenced by postcolonial theory. The underlying assumptions of post-colonialism which includes marginalization has strongly influenced this school of thought and has been expanded to include the consideration of important concepts such as race, ethnicity, and gender. Post-colonialism can be seen as a lens

through which the impact of colonization can be better understood. This was followed by an overview of the conceptual framework which consisted of several important concepts which included decolonization as the main concept as it relates to type II diabetes in Aboriginal peoples. In the following chapter the methodology for this research study will be presented.

CHAPTER THREE:

METHODOLOGICAL PERSPECTIVE

The methodology of a study guides the thinking and provides a lens through which the researcher will determine which methods to use and how these methods will be used to answer a particular research question (Mills & Birks, 2014). The original research question for this study helped to determine how to situate myself as a researcher with the participants as well as with the data that was collected.

This chapter will describe the qualitative and ‘decolonizing’ methodology that was employed for this thesis. A discussion of the origins and principles of grounded theory as well as the data management will be addressed. The participant profiles will be presented as well as the sampling, recruitment strategies, ethical considerations and the criteria for ensuring rigor. The method of data collection, which in this case consisted primarily of semi structured one on one interviews, will be reviewed and an explanation of the process of data analysis will be provided.

3.1 Decolonizing the methodology

The concept of decolonization was initially presented in the introduction and further expanded in Chapter two. The significance of acknowledging the colonial past as well promoting self-determination are two important elements of decolonization (Smith, 1999). There is a growing body of work that is promoting Aboriginal ways of knowing and challenging the traditional ways of conducting research with Aboriginal peoples (Battiste, 2000, 2008; Brown & Strega, 2005; Cochran et al., 2008; Laenui, 2000; Liamputtong, 2010; Prior, 2007; ; Smith, 1999; Wilson, 2008; Zavala, 2013). Consequently “there is an urgent need

for the perspectives of Indigenous peoples to be adopted and valorized in the research process” (Bartlett et al., 2007).

Historically the traditional western approach to conducting research has led to a culture of mistrust and resentment because much of the research conducted in the area of diabetes in Aboriginal peoples has been conducted on them as opposed to with them (Koch & Kralik, 2006; Martin & Mirraboopa, 2003; Waldram et al., 2007; Wilson, 2008). This position was perhaps best articulated by Smith (1999) who wrote: “research is probably one of the dirtiest words in the indigenous world’s vocabulary” (1). This powerful statement captures the essence of the mistrust and apprehension that likely exists with respect to the practice of conducting Aboriginal research especially by non-Aboriginal researchers. Being aware of this perspective is essential.

A classic example of research that was conducted “on” Aboriginal peoples was recently brought to light by Mosby (2013) who published an article detailing the unethical and shameful nutritional experiments that were conducted in Aboriginal communities and residential schools between the years of 1942-1952. This publication clearly outlines how experimental research had been conducted on Aboriginal peoples without their knowledge or consent and represents an indictment of the Canadian government’s research agenda and policy in the not so distant past. It would be expected that this type of experimentation is no longer occurring however it did contribute in a significant way to the exploitation and marginalization of Aboriginal peoples (Rigney, 1999) as well as to the perpetuation of a culture of mistrust.

The traditional western practice of conducting research has also led to absence of legitimizing traditional or Aboriginal ways of knowing and represents one of many ways in

which the colonization of Aboriginal people has been perpetuated (Martin & Mirraboopa, 2003). Researchers went to the communities, conducted their studies, and collected their data never to return to share their findings (Flicker, 2007; Fisher & Ball, 2003). This practice was tantamount to being raided of important Aboriginal knowledge and not receiving any benefit from having taken part in the process.

According to Hingangaroa-Smith (2000) knowledge is not something that is owned by individuals but rather something to be shared with everyone. This perspective is an important one since it served as a guide for this particular research project. In other words the knowledge that was created and generated by this qualitative study will be shared with and belong to the participants involved in the study and the communities that they represent. Some would consider this approach to be decolonizing.

The notions of Aboriginal worldviews and traditional knowledge are also essential components of decolonizing research methodologies. Smith (1999) argues that colonial methods of research have essentially silenced non-Western forms of knowledge such as traditional Aboriginal knowledge. These colonial or dominant research methods have been referred to by Said as the ‘methodology of imperialism’ (Liamputtong, 2010). According to Bartlett and colleagues (2007) by using decolonizing methodologies such as constructivist grounded theory, even when born out of Western thinking, we can promote an “approach to inquiry that does not privilege Western constructs and impose Western conceptions of matters of health and illness upon the research participants” (2372). Furthermore by critically reflecting on the research process and considering essential social, political and cultural elements the researcher is less likely to impose a Western approach on a phenomenon that requires ‘other’

ways of knowing (Brown & Strega, 2005). According to Liamputtong (2010) “the use of qualitative research inquiry and more innovative methods are promoted in decolonizing methodology” (Liamputtong, 2010: 23). That being said, some might argue that unless one uses primarily Indigenous methodologies, one cannot assure decolonization. I would suggest that Western methodologies can also be decolonizing if they adhere to and are sensitive to the principles of decolonization.

Decolonizing methodology seeks to “empower Indigenous communities and respect their culture and traditions” (Liamputtong, 2010: 23). It further seeks to recognize Aboriginal epistemology such as learning from experience and from teachings transmitted through the generations (Brown & Strega, 2005) and incorporate cultural values and beliefs into the process of conducting research (Prior, 2007). This is the position that I have elected to take throughout this thesis. That being said I am not suggesting that the methodology employed for this study can be said to be completely decolonized. I believe that it is unrealistic for a non-Aboriginal researcher, who possesses many biases and western influences, to achieve complete decolonization. What I am suggesting, however, is that I have made every conscious effort to remain as faithful to a decolonized approach throughout this research from the beginning consultation process through the collection of data and subsequent analysis. Perhaps more importantly I am suggesting that I see this study as merely a beginning since it has always been my intention to return to the communities with the findings and seek out further input for any future directions and dissemination of the findings. Decolonization with respect to methodology has always been a goal to strive for as opposed to a given.

3.2 Qualitative Research

It is well supported in the literature that qualitative approaches to inquiry are likely to be the most appropriate when it comes to conducting research with Aboriginal people (Koch & Kralik, 2006; Liamputtong, 2010; Minkler & Wallestein, 2008; Wilson, 2008; Smith, 1999). Qualitative research permits the researcher to explore, understand and describe phenomena in a more in-depth manner (Morse & Field, 1995; Strauss & Corbin, 2008) by concentrating on the experiences of people which often includes their perceptions (Maxwell, 2006). I am not suggesting that quantitative research such never be conducted. What I am suggesting is that questions that seek to better understand complex phenomena such as the impact of colonization on the experience of living with type II diabetes are best answered by utilizing qualitative approaches. Given the research question for this study a qualitative approach was required. Once a determination as to the use of a qualitative approach had been made it also became evident that employing grounded theory seemed appropriate.

3.3. Grounded Theory

Grounded theory provides a systematic methodology that is used to analyze data and assist in the construction of a theory. This methodology provides a way of thinking about and conceptualizing data. Ultimately it does not aim for the truth but rather it seeks to provide a means of conceptualizing what is going on (Charmaz, 2006; Glaser 1978, 2005). With its sociological origins, Grounded theory provides methodological direction which is derived from a fundamental assumption that human behaviour can only be understood within a “collective consciousness” to which members of the group have no interpretive access (Thorne, 2008: 28). In other words, this approach can provide a means to help put into words what a particular group

may be experiencing. Through analysis I am able to begin to identify patterns that make larger sense. This approach helped me to gain a better understanding of the social forces that shape the experience of living with type II diabetes. In this case the goal was to gain a better understanding of the impact of colonization on the lived experience and perceptions about developing type II diabetes for Aboriginal peoples living along the North Shore of Lake Huron.

This study takes a grounded theory approach which is underpinned by a constructivist and decolonization theory (Koch & Kralik, 2006; Minkler & Wallerstein, 2008). This approach promotes a shift from “gathering data on oppressed people” to carrying out research with participants “placing capabilities in the hands of disenfranchised people so they can transform their lives themselves” (Koch & Kralik, 2006, p.12). This is very much in keeping with the principles and intent of participatory and community based research approaches (Minkler & Wallerstein, 2003). I would suggest that this is a lofty goal and that in reality, one can only hope that the participants in this study will at the very least been given a voice that could possibly influence change. This particular qualitative study will also attempt to better understand the ways in which reality is socially constructed (Morse, Noerager-Stern, Corbin, Bowers, Charmaz, & Clark, 2009).

3.3.1 *Constructivist Grounded Theory*

According to a study conducted by Bainbridge, Whiteside and McCalman (2013) a constructivist grounded theory approach can be seen as decolonizing since it:

(...) can help to legitimize the experience of Aboriginal as a source of knowledge and facilitate the development of theory directly interpreted from Aboriginal people's own

words. It also acknowledges the influence of contextual social processes and structures, the diversity of experience, and the relational aspect of the research enterprise (278).

Similarly Bartlett and collaborators (2007) have suggested that grounded theory in particular has qualities that are consistent with a decolonized approach to conducting research “because the outcomes are generated through a process of reflection that helps to determine new information that is required to build an emergent theory” (2379). I would suggest that knowledge and grounded theory are mutually constructed by both the researcher and the participants with an aim to interpret empirical evidence within the research context.

According to Charmaz (2009) constructivist grounded theory is essentially a revised version of Glaser and Strauss’ classic grounded theory.

It assumes a relativist epistemology, sees knowledge as socially produced, acknowledges multiple standpoints of both the research participants and the grounded theorist, and takes a reflexive stance toward our actions, situations, and participants in the field setting-and our analytic constructions of them (129).

3.4 Researcher Reflexivity

I will begin by making it clear that I view constructivism as the research paradigm in which I am situated and that grounded theory as a method of analysis of the data that was collected. When utilizing a constructivist approach the assumption being made is that the researcher comes to the field with preconceived ideas, notions, experiences and theories about any given topic and that it is important that they are aware and able to not only reflect but address these throughout the research process (; Charmaz, 2006, 2009; Mills & Birks, 2014). This view of the researcher’s positioning in relation to the topic under study is also considered

fundamental to Aboriginal research methodologies (Brown & Strega, 2005). According to Sinclair (2003) the purpose of location in Aboriginal research means “revealing our identity to others; who we are, where we come from, our experiences that have shaped those things, and our intentions for the work we plan to do. Hence ‘location’ in Indigenous research, as in life, is a critical starting point” (122). The role I have played throughout this research process was initially introduced in the introduction in the form of situating myself in the study. I will now embark upon deeper reflection with respect to my role as researcher.

It is important to state that I am a white male who is attempting to reach an understanding of a concept from the perspective of a French Canadian male Nurse Practitioner. Although I have had some experiences that might resemble marginalization and oppression inflicted by the dominant Anglo European society I do not believe that I am in any position to draw comparisons between my experiences and those of Aboriginal peoples. My own experience has perhaps provided me with a small glimpse into how dominant groups or cultures can have an impact on minority groups. Ultimately I believe that it is my personal and professional experience of working with Aboriginal peoples and in their communities over the last 25 years that have equipped me with a more empathetic view of how colonization has and continues to impact Aboriginal peoples today.

I think it’s important to make this declaration since those who have been impacted directly by colonization, in this case Aboriginal peoples, could take exception with my attempt at explaining a concept that has not had a direct impact on me. I can acknowledge that by having had the privilege of working in various First Nation communities in Ontario over the last 25 years I have had the opportunity to witness first hand not only the outcome of colonial practices

but unfortunately the ongoing impact that it continues to have today particularly in the area of diabetes care. It is this experience that has led me to want to better understand how colonization has impacted Aboriginal peoples' experience and perceptions about developing Type II diabetes.

I am a non-Aboriginal person who has viewed this problem from a predominantly clinical and biomedical perspective. Throughout this process I had to recognize that I would attend various roles such as researcher, doctoral student and nurse practitioner. I made a conscious effort to separate my clinical role from that of researcher. Since I have a history as a Nurse Practitioner in some of the First Nation communities in which I conducted the interviews I attempted to remain conscious of the fact that I may be viewed first and foremost as a clinician. Ultimately I hoped to gain a better understanding of how colonization may have impacted the experience of living with type II diabetes from the perspective of Aboriginal people living in First Nation communities along the North Shore of Lake Huron as well as the care that is being provided.

It was important that I situate myself within this proposed research project and that I take into account my personal experiences and values recognizing how these might influence my analysis and interpretation of the data I collected (Koch & Kralik, 2006; Mills & Birks, 2014). I needed to both recognize and capitalize on the researcher as instrument. I also needed to explain how my personal thoughts and feelings influenced me throughout the analytical process. I arrived with preconceived notions and biases that I need to identify, confront and consider throughout the research process. For example it is my contention that this is the only way to change the way in which diabetes has been understood and conceptualized from a primarily Western biomedical perspective.

Another important consideration was to examine my intent and motivation in conducting this study. As a primary health care provider who is perhaps more familiar with the importance of how the historical and ongoing legacies of colonialism I have committed to sharing my findings in an attempt to better educate them on the historical and ongoing impacts of colonization. Ultimately I hope that the results from this work will have a positive impact in educating and informing my non-Aboriginal and Aboriginal health care professional colleagues alike. It is my hope that both awareness and importance of understanding how colonization might impact health care delivery.

Finally I must be aware of the potential for a power differential that often exists between the researcher and the researched. It was important that I remain aware of this possibility and make every attempt to mitigate its possible impact at all times. For example during the interview process it is possible that some of the participants might be careful about what they say because of who I am and what I might represent to them. Although I was in control of the process of conducting this research I did seek out and receive direction in terms of the direction in which I was taking the research.

In qualitative inquiry it has long been acknowledged that the researcher and research have a reciprocal impact given the complexity and interpretative nature of this form of inquiry (Creswell, 2007). This reciprocity takes place by reading the interview transcripts literally, reflexively and interpretively from the beginning to the end. As I immersed myself into the interview transcripts and by listening to the interview recordings I made it one of my goals to tell the participants' stories all the while keeping my research question at the forefront.

3.5 *Ethical considerations*

Before proceeding to the university ethics review process I decided to consult and obtain approval to conduct this study from the North Shore Tribal Council communities. According to Maar and collaborators, (2011) “adhering to a proper process of gaining community authorization for a study, which requires permission from the community leadership” is essential (Maar et al., 2011: 751). I was provided with direction on how to proceed in order to obtain community approval or buy in and on March 30, 2011 the proposal was accepted by the North Shore Anishanawbek Health Steering Committee on behalf of the seven First Nation communities along the North Shore of Lake Huron (Appendix A). It was my belief that community endorsement was required before considering submitting a formal ethics proposal through the university.

Laurentian University Research Ethics Board (LU-REB) approval was obtained prior to conducting this study (Appendix B). All of the participants were provided with an opportunity to review and complete an informed consent form prior to participating in the interviews and were given the option to withdraw at any time from the study without fearing any consequences. The participants were each offered an honorarium of twenty dollars for agreeing to participate in the study. They were advised that they could keep the honorarium even if they elected to withdraw from the study. The interviews were completed within 6 months and took place between November 2011 and April 2012. There were no deviations from the original research protocol in terms of recruitment or consent forms.

All research related materials collected such as signed consent forms and digital audio recordings of the interviews were kept in a locked cabinet during the study that was only

accessible by the principal investigator. The identity of each of the participants was assured and maintained through the allocation of participant numbers in lieu of names. This research study was conducted by a researcher who had undergone training and received a certificate by completing the “Interagency Advisory Panel on Research Ethics’ Introductory Tutorial for the Tri-Council Policy Statement: Ethical Conduct for Research involving Humans (TCPS)” in September of 2009 prior to conducting the interviews.

All audiotapes were transcribed by professional transcriptionists who were not familiar with the participants or the communities in which they were conducted. There was no identifying information in the audiotapes that could be linked to any individual as the participants were always encouraged not to use names or identify places during the interviews.

3.6 Recruitment and data collection procedures

In the following section I will take this opportunity to introduce the participants who ultimately provided me with these stories and personal experiences.

3.6.1 Recruitment of the participants

Initially the recruitment of participants for this study targeted Aboriginal male and female individuals over the age of 50 from each of the seven participating First Nation communities along the North Shore of Lake Huron. In reviewing the literature it is apparent that the majority of individuals with type II diabetes tend to be between the ages of 40 and 59 years of age. However after careful consideration of the literature with respect to colonization and Aboriginal peoples I elected to remove the age limitation in order to be more inclusive. I did however specify that participants had to be adults over the age of 18 and have lived with type II diabetes for a minimum of 5 years in order to obtain a sample of participants who had more

experience and familiarity with this disease (CDA, 2013). It was anticipated that individuals who have lived with type II diabetes for a minimum of five years would find it easier to share their experiences. By broadening my inclusion criteria I wanted to lessen the possibility of excluding participants who may have a lot to contribute but who would have otherwise been excluded from participating (Appendix C & D).

In addition to community status the participants were required to be English. I recognized that this language limitation might be problematic and ultimately would be identified as one of the potential limitations of this study. Individuals, who did not self-identify as Aboriginal, had type I diabetes, or were unable to give consent to participate were not considered. The rationale for the inclusion criteria included was to invite Aboriginal peoples from the targeted communities in order to obtain the richest possible sources of information to help address the research question.

Participants were invited to take part in this study through their community health centres. The nurse from the North Shore Tribal Council Diabetes Education Program “Naadmaadsaan” (helping oneself), in conjunction with clerical staff in each of the health centers located in the First Nation communities along the North Shore of Lake Huron, was asked to initiate contact with the prospective participants. Involving the communities in the recruitment of participants provided an opportunity for participation into the process. They were instructed that participants had to be residing on reserve to participate in this study. Interested participants were provided with an information letter regarding the purpose of the study (Appendix E) and those interested were asked to review and sign a consent form (Appendix F). The diabetes nurse and clerks who

assisted with the recruitment were asked to keep track of all of the participants that were contacted in order to determine response rates. Participant recruitment began in May 2011.

3.6.2 Participant Profiles

A total of 22 participants were interviewed. A comprehensive table of demographic information collected can be found in Appendix E. All of the participants from this study currently lived in their First Nation communities (see Table 1).

Table 1: Participant profiles

Participant #	Gender	Age	# of years with diabetes	Treatment
1	F	45	13	INSULIN
2	F	65	17	MEDICATIONS
3	F	66	12	INSULIN
4	M	61	20	INSULIN
5	M	56	5	MEDICATIONS
6	F	60	14	INSULIN
7	F	61	14	INSULIN
8	M	61	16	MEDICATIONS
9	M	56	21	MEDICATIONS
10	M	78	13	INSULIN
11	F	55	10	MEDICATIONS
12	F	61	7	INSULIN
13	F	64	30	INSULIN
14	M	46	29	INSULIN
15	F	53	8	MEDICATIONS
16	M	70	22	MEDICATIONS
17	F	72	15	INSULIN
18	M	62	30	INSULIN
19	F	68	8	MEDICATIONS
20	F	59	27	INSULIN
21	M	63	20	MEDICATIONS
22	F	60	30	INSULIN
	13 Females 9 Males	45-78		

In this table we can see, there were 13 women and nine men ranging in age from 45 to 78. Some of them had been living with diabetes for as little as 4 years and as long as 30 years for a couple of the participants. The sample consisted of individuals from all seven of the First Nation

communities along the North Shore of Lake Huron. Thirteen of the participants were being treated with insulin while the remaining eight were managing their diabetes with the help of medication. Typically individuals who are being treated with insulin have lived with diabetes longer than individuals who may be treated with diet and oral medications. Therefore individuals who have lived with diabetes longer will have had more experience with the disease.

In addition, the participants had diverse education backgrounds. Four of the participants had completed elementary school; thirteen had a secondary school education while 5 had completed a post-secondary education. Ten of the participants had retired from work, three were receiving a disability pension, 4 were self-employed, 2 were employed in the health care field, there was one labourer and one identified herself as a homemaker. Fourteen of the participants were married, one identified their status as living common-law, three were widowed, one individual was separated and three were single. All 22 of the participants that ultimately formed the sample for this study had a familial history of diabetes. The purpose of this table and profile description was to provide a general description of the participants as well as provide some context. It was not meant to provide an analysis of the make-up of the study participants which could be addressed at a later date.

3.6.3 *Data collection procedures*

Data was collected through in-depth unstructured interviews using an interview guide (Appendix F). The interview guide was inspired by the key concepts identified in the theoretical and conceptual underpinnings for this study (Creswell 2007). They were conducted in the homes of the participants or in another mutually agreed upon location and lasted on average between 1 and 2 hours.

The interview questions which derived from the key concepts of culture, health and diabetes were broad and open ended in an attempt to get the participants to share as much of their experience as possible and in order to avoid being treatment focused. In spite of this inevitability the participants discourse was laden and governed by the biomedical with respect to diabetes as they often reverted to discussing the traditionally focused upon dimensions of diabetes self-management such as taking medications, following a strict diet, monitoring one's blood sugars, exercising and medical monitoring with their Western health care providers. In addition to the use of open ended questions probes such as "can you tell me more" were also used. Whenever required clarification was sought throughout the interviews in order to ensure that what the participants were sharing was being understood.

I deliberately elected not to collect any of the demographic data until the end of the interview. My rationale for waiting until the end to ask these types of questions was to avoid setting up a context of an interview that was solely based on diabetes and how it is treated. I was concerned that by beginning with collecting demographic data I might be signaling that my interest was in the typical aspects of diabetes management such as taking medications and monitoring one's blood sugars. My clinical experience has taught me that in order to obtain more in depth detail from my patients I need to use more open ended and broadly stated questions. I wanted to explore other aspects of diabetes such as how it related to their culture, what meaning it had for them, and how they navigated the health care system.

Demographic data collected from the participants included contextual information that was used to assist in interpreting the participants' perceptions of their experience of living with type II diabetes. The information included age, gender, living situation, socioeconomic status,

occupation, marital status, educational achievements, date of diagnosis, treatment regime (e.g. diet, medication, and insulin), co-morbidities, the presence of any diabetes related complications, and family history of diabetes (Appendix I). Demographic data and interview transcripts were analyzed concurrently throughout the collection of data. Each of the interviews was audiotaped using a digital recorder. The entire interviews were transcribed verbatim by a qualified transcriptionist. All interview transcripts were read and analyzed by the researcher using the constant comparative method that resulted in the identification of codes, followed by concepts and then the identification of core categories that had emerged

Each of the phases of analysis was interconnected and did not proceed in a linear fashion but rather utilized a constant comparison method. The constant comparative method is a process in which any newly collected data is compared with previous data that was collected. According to Hutchinson & Wilson (2001) the constant comparison method is fundamental to grounded theory and it aims to generate theoretical constructs which combined with codes and categories that emerge develop into a theory that helps explain the phenomenon of interest. Constant comparative analysis also helped to group concepts under higher order categories (Corbin & Strauss, 2008). Each interview recording was reviewed on at least 4 separate occasions. The first review was generally done immediately after the interview had been completed. The second review was completed once the transcriptions were received and used as means to verify the transcriptions for accuracy. The third complete review of the interviews took place during the beginning of the in depth or comparative analysis phase of the interviews at a point in time when the coding for themes had been done, the principal categories had been identified across all interviews and individual interview diagrams or summaries had been created containing a

conceptual map of the key points of the interview represented in a mapping document in order to be able to appreciate the inter relatedness of the categories. At times a fourth review of the audio recording took place in order to ensure that the interview excerpts being used as analytic evidence were an accurate representation of the category or concept being addressed.

It is important to note at this point that although I did strive for verbatim transcription of the interviews I agree with Noerager-Stern (2009) that ultimately even if the words are not transcribed verbatim or exactly as they were said that the final outcome of the study will not be affected or damaged “because a grounded theory is a theoretical interpretation of a conglomerate of data rather than a case report of a series of incidents” (Noerager-Stern, 2009: 58). Subscribing to this notion somehow gave me reassurance that even if some of the participant’s words had not been in some cases transcribed exactly as they were said that ultimately my research would not in any way be compromised.

3.6.4 *Theoretical sampling*

The practice of data collection in grounded theory is guided by theoretical sampling. Initially a purposeful sampling approach was used to recruit individuals into this study. As the process evolved other methods such as theoretical sampling were employed (Charmaz, 2006; Charmaz, 2008). The data collection was continuously directed on the basis of concepts that emerged during each of the interviews and this subsequently guided me in which questions to continue to ask, how to ask them and which concepts I needed to further explore in order to look “for data that would bring out these concepts...” (Morse et al., 2009: 45). Theoretical sampling is influenced by memo writing and needs to be ‘strategic, specific, and systematic’ (Charmaz, 2006). It occurs as a part of the analysis which begins as soon as data is collected

and is further influenced by categories that begin to emerge during the course of the analysis. In other words over the course of conducting the interviews as well as in between the interviews themselves I was able to theoretically determine what direction and focus to further pursue and elaborate in future interviews based on initial analysis and memos that were being developed. According to Charmaz (2006) “the movement back and forth between category and data in theoretical sampling fosters raising the conceptual level of your categories and extending their reach. As you develop your categories, you can see which ones to treat as major concepts in your analysis” (Charmaz, 2006: 121).

Another important aspect of data collection is the ability to determine when it is no longer necessary to continue to gather data, or as in this case, continue to interview participants. The projected total number of participants that was initially targeted at the outset was between 21 to 35 individuals. This was based in part on my review of the literature on grounded theory which suggested that for grounded theory typically 20 to 30 individuals are usually required to develop a well saturated theory but this number could potentially be greater (Creswell, 2007). Eventually I was able to determine that I had recruited enough participants when “gathering new data no longer sparks new theoretical insights, nor reveals properties of these core theoretical categories” (Charmaz, 2006:113).

3.7 *Data management and analysis*

The analysis of data for this study was informed by principles of a constructivist grounded theory approach, was multifaceted and consisted of many steps (Charmaz, 2006; Charmaz, 2009). This iterative process involved a cycle of data collection and analysis which

subsequently informed ongoing data collection. This method of analysis which is inductive in nature is common in qualitative methodologies (Creswell, 2007; Morse & Richards, 2002).

The act of simultaneously collecting data and analyzing the interview transcripts helped to shape the questions and to redirect the interviews as the research advanced (Creswell, 2003). As a consequence the interview guide and questions changed and evolved over the course of the interviews. This approach also helped to determine when enough data had been collected because categories became ‘saturated’. That is, it becomes evident when continuing to collect data “no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories” (Charmaz, 2006: 113).

There are various approaches to analyzing the data when using a grounded theory methodology. In reviewing the literature it becomes apparent that the constructivist approach is somewhat different from the more classic Glaserian approach (Charmaz, 2006). As previously stated, the constructivist approach in particular is considered by many authors as being decolonizing since the theory that emerges is interpreted from the words of the participants themselves, in this case Aboriginal peoples (Bainbridge et al., 2013; Bartlett et al., 2007). I will now provide the reader with a brief description of the grounded theory analysis that was undertaken for this study.

3.7.1 Overview of analysis process

A systematic and consistent approach to the analysis was employed throughout this study. The analysis of data occurred simultaneously while it was being collected (Creswell, 2003). Each of the transcripts was reviewed while listening to the original interview shortly after they took place. This provided an opportunity to clarify and or make any corrections to the

actual transcript. The transcripts were then read a second time in order to identify emerging themes. During this review I was looking for key statements, repetition and contradictions within the transcripts. The themes were reviewed and emerging concepts were eventually grouped into categories. Once a key category was developed its properties and dimensions were also identified. I also endeavoured to identify the conditions under which the categories appeared to arise as well as how it related to other categories (Charmaz, 2006). My analysis consisted of four phases, namely a thematic, conceptual, dynamic and comparative analysis. Documentation of the analysis process took place on the transcriptions themselves as well as through the use of Word documents on which notes and tables were employed in order to gather, track and manage the information. I will now provide a brief description of each of the phases in the following section.

During the thematic analysis all of the major themes that evolved from the transcripts were identified. As I reviewed the data collected, repeated ideas, elements and concepts became apparent and were labeled using codes. When necessary a review of the available and related literature was performed. This review of the literature assisted me in explaining some of the emerging themes that were identified.

This was followed by the conceptual analysis of the data. During this phase I was examining the data in relation to my original research question which sought to explore the impact of colonization on the experience of living with type II diabetes. The purpose was to uncover social representations of concepts that emerged from grouping themes that were identified during the initial phase of the analysis process. As more data was collected and reviewed themes that were initially identified were grouped into concepts and subsequently into categories.

During the dynamic analysis I constructed a summary diagram for each of the interviews (see Appendix J for an example). These summaries were developed in order to establish which categories were the most significant from the interview data and then making a direct link between the central and the underlying categories. During this phase of the analysis areas of contradiction that emerged between the categories were explored. These interview summaries ultimately provided me with a snap shot of each of the interviews which allowed me to uncover the essence of what was being shared by the participants during the interviews.

Finally in the comparative phase I undertook to compare and contrast each of the interviews. During this phase I also relied on post interview field notes which had been completed following each interview as well as related theoretical and empirical literature (Paillé, 1994). The purpose of comparing interviews was to identify commonalities and contradictions between and among the interviews. The interview summaries for each of the twenty two interviews developed during the dynamic analysis phase facilitated the process of comparison across all of the interviews. It was through comparing and contrasting data collected from different participants that allowed me to determine that no new themes or concepts were arising or being identified. It was also during this phase that the three main categories were developed and their associated properties and dimensions emerged. The analysis of the interplay between the categories ultimately assisted in the development of the substantive theory that emerged.

3.7.2 *Theorizing in grounded theory*

One of the goals in grounded theory methodology is to ultimately construct a theory that is 'grounded in the data' that has been collected (Mills & Birks, 2014; Charmaz, 2008; Charmaz, 2006; Glaser, 2005; Morse & Richards, 2002; Glaser, 1978). One of the distinctions

of constructivist grounded theory is that it is not assumed “that theory emerges from the data; rather they believe researchers construct the analysis of the data and thus the categories and core category that eventually makes up a grounded theory” (Mills & Birks, 2014, 111). In other words a theory that has been constructed based on the analysis of data exploring a particular phenomenon. Value is placed on the participants’ perspectives by focusing on their everyday life experiences. In this case the experience of Aboriginal peoples who have been colonized and living with type II diabetes was explored in order to better understand the experience and ultimately come up with a theory on how to promote a decolonized model of diabetes care for this population. The substantive theory that emerges will be based on a conceptualization of the participant’s words.

According to Charmaz (2006) the end result or theory that is developed using grounded theory methodology can take many forms including: 1) an empirical generalization, 2) a category, 3) a predisposition, 4) an explication of a process, 5) a relationship between variables, 6) an explanation, 7) an abstract understanding, and 8) a description. In classic Glaserian grounded theory the notion of identifying a basic social process is often encountered. Glaser (1978) has suggested that pursuing a basic social process can force the data and therefore should only occur if it emerges naturally. This notion is further supported by Charmaz (2006) who warns that when employing a constructivist approach the discovery or explanation of a basic social process may not work and that it will depend on the data and phenomenon being explored. In spite of my contention that colonialism represents an important ‘contextual social process and structure’ that continues to exist and influence the diabetes care experience of Aboriginal peoples, I could automatically expect that a basic social process would emerge. Ultimately the

final product or theory's form will be determined by the analytic process that was undertaken and may not necessarily result in the elaboration of a basic social process.

According to Creswell (2007) "the result of this process of data collection and analysis is a theory, a substantive-level theory, written by a researcher close to a specific problem or population of people" (Creswell, 2007: 67). A substantive theory which provides a theoretical explanation or interpretation for a particular area differs from a formal theory which tends to be more abstract and applicable to a wider range of issues (Strauss & Corbin, 2008). This is important to mention since the substantive theory that will ultimately be presented will have its limitations.

The selection of grounded theory methodology is influenced by the researcher's ontological and epistemological views since these will influence the types of questions being asked and how they are being asked. These views also ultimately influence how theory is understood and constructed. The practice of theorizing and coming up with a theory using this methodology is guided by an inductive and iterative process that involves a number of analytical steps or procedures such as coding and writing memos in order to identify key concepts and categories that appear to be part of the experience of the majority of the participants and helps to bring meaning to their collective experience. According to Charmaz (2006) grounded theory seeks an interpretive definition of theory which "calls for the imaginative understanding of the studied phenomenon. This type of theory assumes emergent, multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual" (Charmaz, 2006: 127). Ultimately I elected to use a grounded theory methodology because the focus of this study needed to be on the experiences and views of the

participants and there appears to be a lack of any existing theory to explain the impact of colonization on the experience of type II diabetes in Aboriginal peoples or how diabetes care can be decolonized.

The previous discussion was meant to provide the reader with an overview of the steps involved in the process of conducting a constructivist grounded theory analysis. The actual process was quite involved, time consuming and labour intensive. This brief explanation cannot possibly paint an accurate picture of a process that is quite complex however it can provide some insight and assist the reader to gain a better understanding of how the data collected was managed, interpreted and ultimately analyzed. It was also the intention to help clarify the steps taken to help arrive at the development of a theory for this study that was grounded in the data collected.

The importance of adhering to the principles of a qualitative research methodology that is considered to be decolonized has been stressed on several occasions. The notion of community participation and involvement are also important elements when considering a decolonizing approach. These elements were also considered as they relate to the analysis of the data for this study. However and for obvious as well as pragmatic reasons, the participants from this study did not actively participate in the analytic process. According to Minkler & Wallerstein (2008) communities are often not involved in the actual analysis of the data for a number of reasons including lack of interest, time, or a clear understanding of the process. I would suggest that all of these reasons applied in this particular study.

I intend to return to the communities upon completion of the study to present the findings and encourage further engagement with respect to the findings that emerged as well as

to seek community input regarding the elaboration of next steps. It seemed clear from the outset that being provided with the results as well as an opportunity to provide feedback with respect to the results and future directions was always the intention.

The analysis process for this study began during the first interview. It was carried out in an inductive and iterative manner. Strategies such as coding, writing memos and theorizing, which are all inherent in the process of conducting a constructivist grounded theory approach, were described. The criteria that are being proposed for judging the quality of this particular study were also presented and discussed.

3.8 *Summary*

In Chapter three I have introduced and explained the qualitative constructivist grounded theory methodology that was used for this study. This included a discussion on the data collection and management procedures. The notion and importance of employing a decolonizing approach to conducting this research was also presented.

The following three chapters will present three emergent categories and their associated properties and dimensions which represent the main findings of this study. The categories were ultimately identified through a process that involved constant comparison and a thematic, conceptual, dynamic and comparative analysis. The use of transcription excerpts consisting of the participants' own words will be used throughout the findings chapters as analytic evidence to help demonstrate and bring meaning to the individual and collective experiences of living with type II diabetes.

CHAPTER FOUR

CHANGING WAYS OF EATING

The previous chapters provided an introduction to the study and a justification for the design and methods that were used to carry out the research. This first findings chapter will present the first emergent category which was eventually named *changing ways of eating*. This category emerged in response to the participants' perceptions of how over time, often characterized as contrasting then and now, the way in which they lived had changed. Given that the focus of the study was on living with diabetes the participants seemed to place a particular emphasis on ways of eating and how this had changed from depending on the land in the past to having become more dependent on Western ways of eating over time. The discourse surrounding food and eating often took a rather interesting trajectory. What became clear was that for most of the participants the link between culture and ways of eating then and now were closely related.

There were several questions that prompted the participants to begin sharing and discussing their diets and food choices. These ranged from general questions about their culture to simply being asked to talk more about food and eating when the topic came up. When the participant would share about their present situation they often made comparisons to the way things used to be. For some of the participants ways of eating had changed significantly while for others this was not the case. Often they provided justifications for why things have changed with respect to their connection to the land and ways of eating. As themes emerged from one interview to the next I was provided with queues and ideas to pursue in subsequent interviews.

The following section will provide the reader with a detailed description of the two properties and associated dimensions related to the category *changing ways of eating*.

4.1 *Being connected to the culture and land*

The first property related to *changing ways of eating* was being connected to the culture and the land. The participants were all asked to describe what their culture represented for them and if they saw a connection with living with diabetes. One of the participants suggested that having feasts, which is a common part of her culture, is particularly challenging when you have diabetes since it often involves eating foods that may not be ideal: “*we have gotta have a feast...like seems like we are eating lots more than before.*” (P2)

Although a clear link was not always made at the outset with diabetes they eventually were able to connect their illness with their culture through the way they used to eat and how they now accessed their food. This change was evident in the following participant’s account: “*we used to be able to live off the land before...younger people, they don’t live off the land now.*” (P3)

Another participant also seemed to suggest that changing ways of eating had occurred over time: “*As I look at it, our staple, our diet changed and that’s because we, as are. Like my older brothers as they start growing up, you know, the diet started to change somewhat.*” (P 9)

What seemed to emerge from many of the participants who felt a connection with their culture was how they lived and their relationship or views about the land. Although this participant did not use the word land it was implied: “*I’ve always had a connection to trees and to nature.*” (P 12)

Although this connection was seen as different from the way it once had been for their ancestors the connection remained. It seemed natural for many of the participants and one might even suggest necessary to link food and eating with their culture and the land. *“For me culture represents the foods we eat.”* (P 12)

Some of the participants were able to provide a general explanation of what their culture meant to them. For example one participant shared that: *“culture is um the way of our life, our teachings, what we believe”* (P 15). More detailed explanations were also provided and will be addressed in the following sections.

Often following the discussions about culture would come stories of the way things used to be which for some was often characterized as living off the land and examples of what represented traditional ways of eating and foods. *“What I’ve been hearing is that long time ago we ate off the land”* (P18).

There were three dimensions associated with the property of being connected to the culture and the land which included giving meaning to the culture, living off the land, and traditional foods. In the next section the three dimensions of being connected to the culture and land will be illustrated with data from the participant interviews.

4.1.1 *Giving meaning to the culture*

The first dimension of being connected was how the participants seemed to *give meaning to the culture* which is conceptualized as the way in which some of the participants explained what their (traditional?) culture meant and represented for them. Even though they were asked to explain their culture in the context of living with diabetes many of the participants focused on culture in a general sense. The idea of culture as a way of life fared prominently for many of the

participants. For example one participant shared that for her culture is simply a part of life for Aboriginal people: *"I live in an Aboriginal community and culture is just part of life with us"* (P1).

Similarly participant also used the words a way of life to describe what her culture represented for her: *"I'm Native, born Native, umm, it's a way of life, a way of doing things, that's been taught to you from the time you were small ... that's the way you do it, that's your culture. How you do things in your life. That's what it means to me I think"* (P17).

For two participants, the culture was also a source of pride: *"I'm very proud to be a you know to be a First Nation's person...it's you know it's what you have in heart, what you have in your heart, and you know that in your heart that you're an Ojibwe Indian eh, you know"*. (P 19)
And,

"I'm very proud that um of my Native language, um and I'm also proud of, of uh the um culture, like the powwows, um and we have Native crafts and I'm learning how to make um moccasins". (P 20)

Several of the participants talked about how for them culture not only represented a natural or simple way of life but also were able to make a link with food and a connection with the land. One participant provided a number of examples that represented this way of life: *"For me culture represents the way that we're raised. You know how were raised what we link too, the foods we eat, every part of our life, our religion and our umm, our parentage. Umm, any type of uh, uh link with dancing, music. Uh, it's a way of life."* (P12)

For another participant, hunting represented a simple way of life and was something that she considered to be a part of the culture. A link between culture, ways of living and access to

the land through hunting was made by this participant: *“I want things to be simple for my kids to and to make sure that they have those, that culture and my husband you know teaches the kids hunting.”* (P1). For this participant the notion of simplicity, which she appears to value, meant that hunting as an example is a way in which her children might perhaps experience this notion of simple living.

For one participant the way of living was conceptualized as living off the land: *“we Natives, we’re able to live off the land. Like, we’re able to, because of our culture, live off the land in uh, I suppose just, just uh, a natural way of life in those days is what you have to respect eh. That’s why, the culture you can never forget where your background is eh.”* (P3)

The dimension of giving meaning to the culture became significant in relation to changing ways of eating because it provided a context that helped to explain why some of the participants might be more connected to the culture and land than others. Most of the participants were able to make a link between their culture and a way of living by providing various examples of practices, rituals and beliefs. These were often associated with a way of living that some considered being unique to Aboriginal peoples. For some of the participants their culture was changing and for one of the participants had even been stolen from them. *“First Nations culture? Well, as you are probably well aware that our culture was, was kind of taken from us and we were in limbo for a lot of years.”* (P12)

For many of the participants who seemed to have a connection with their culture and land the idea that their culture had been taken was a recurring theme. In spite of this there seemed to be a sense that for several of the participants at least remaining connected to their culture was important and often tied to their relationship with the land.

Through the numerous examples provided representing what culture meant, and in particular the idea of culture as being a way of life, the concept of living off the land and its connection with food seemed to emerge and became another dimension of being connected to the culture and land.

4.1.2 *Living off the land*

Living off the land is defined as the ways in which the participants recounted how some used to access food and in some cases may still be doing. The more traditional view of living off the land in that past would have focused on hunting, fishing and harvesting what grew naturally however for these participants the notion of living off the land also included what some seemed to consider European ways such as farming, planting, and growing even though it has been well demonstrated that some Aboriginal groups did practice horticulture prior to European arrival. Some of the participants made reference to all of these while others seem to give the impression that there was more reliance on one over the other. For one participant farming was a way in which food had been provided for his as well as many other families:

“... back then we farmed, a lot of communities, a lot of families here in the community, they farmed, I know my grandparents uh like I said earlier they had a farm and they uh moved from [place] to [place] and uh they farmed here also, they grew their own and uh that’s what we lived on is uh uh you know, what was provided for us...” (P5)

This participant went on to suggest that this way of living was simpler: *“Ya, everyone does that but uh uh like I said, making it simple back in the day was uh like I said farming, stuff like that eh and and uh just uh you know uh living a simple life ...and you took things in stride*

eh”. Gardening seemed to be a common practice for many of the participants. For example another participant shared: *“Just like the gardens, some people had gardens, planted that ...hard work. Ya, ya, well, if you if you want to eat, you gotta gotta work too, you know. I learnt young (...) some day you’re gonna know what I’m talking about...and now, they realize, go in the city, come true (...).”*(P16)

Some of the participants provided specific examples of foods that were commonly grown in the past. For one participant potatoes seemed to be an important food: *“...we did grow our own ahh like potatoes ... it was mostly potatoes...”* (P4)

Another participant was able to provide a contrast between foods that had been planted with those that came from the land and grew naturally:

“We go pick up uh, wild potatoes, everything that grew natural eh. Like wild potatoes Uh, umm, different types of roots. There was even wild uh, wild umm, turnip... Even, even like uh, the different kinds of plants that are weeds were, were food... Even the, the, the wild flowers, like dandelions and stuff like that. That was all food, you know. So everything was already there. We didn’t have to plant it in other words.” (P9)

This distinction between naturally occurring foods and those that were planted was seen as important for the participants that viewed and represented living off the land in the more traditional or ancestral sense. That is for some the notion of living off the land meant that you ate what was already there as opposed to others who viewed living off the land from the more European way which often consisted of planting and growing things to be consumed. Once again it seemed that certain practices or foods, especially those obtained through horticultural means were at times viewed as exclusively European ways by some of the participants in this study.

One participant provided a good example of what represented, for him, European ways of living off the land when he talked about growing potatoes as well as carrots but went on to add that during the winter months they needed to rely on the land for food through hunting wild game:

“Well we were raised on uh, everything was grown, we had a garden back here, a long garden, my father planted potatoes, carrots and all that eh so that’s what we survived off and during the winter months and also wild meats, moose and deer and uh beaver. That’s things like that eh? You know, for us to meat during the winter time, that’s what we had” (P6.)

What this participant was pointing out was that in the past, and as a result of living in a climate that had different seasons, it was not possible to survive solely on foods that were grown and that during seasons in which growing was not possible there was more reliance on hunting as a means of living off the land. Their words represent a good example of how living off the land had evolved over time to include a combination of what some believed to be European methods of growing and harvesting with what was understood as more traditional and natural practices such as hunting wild game.

For a participant living off the land also represented a simple and convenient way of living;

But yeah when I look back, it was simple, you know? It was just, if you wanted uh, you wanted to have something different for supper you went out to the bush, you shot a couple of partridge. We’d come home. You would have partridge for supper, you know

and your mom would make potatoes and dumplings and scone and, my god that's how simple it was. (P9)

For some the ways of the past, which often consisted of living off the land, were viewed as a simple way of living while for others this was not the case as the modern conveniences seemed to have made life simpler. The notion of simplicity of living off the land seemed to emerge more frequently amongst some of the older participants compared to the younger participants or those who had not had the experience of doing so therefore not really being able to appreciate the simplicity of living off the land which was probably a foreign concept or practice for them.

Hunting was also a common practice that was associated with living off the land for many of the participants. For example two participants both recounted stories of hunting for food: *A long time ago, a long time ago, they went out hunting for their meat and they knew how to smoke it and salt it and keep it for the winter without fridges and whatever...* (P 17)

And, *"...when I was a little girl my father would go to there was a big area I guess and uh he always he'd always go with members of my family uh of his family, his uh brothers, and they'd be gone all day and uh at night usually they'd come home with a deer or a moose. (P 20)*

Not all of the participants interviewed had been raised to live off the land but even if they hadn't they were still able to understand what it meant even if this had not been their experience. For the many participants who were raised living off the land, several examples of types of foods and methods of accessing food were provided. In the following section I will present examples of what many of the participants considered to be traditional foods or ways of eating as well as

some of the methods commonly used to prepare foods in the past. Traditional foods became the third dimension of being connected to the culture and land.

4.1.3 *Traditional foods*

In the previous section I provided examples of how many of the participants' accessed foods which for many was equated with living off the land, that is, obtaining and accessing food that had either been raised or grown, harvested from the wild, or hunted. Many of the participants appeared to characterize foods as being traditional or having been part of their diets and with a few exceptions were able to provide numerous examples of what represented traditional foods and ways of eating. *"So traditional food to me is...corn bread, moose meat, deer meat, muskrat, beaver, rabbit, duck...that's real traditional food...picking food up off the ground like fiddleheads, mint, Labrador or cedar tea...that's traditional food, that's real tea."* (P9)

Some of the participants even made a link between traditional foods and poverty. One for example was the participant who was perhaps able to best characterize what was meant by traditional foods, that is, for her a clear distinction was made between food that was obtained from the "bush" and food that was purchased. For her this was what represented traditional food: *"A long time ago they said we only used to eat Native food, food from the bush and not eat your paid food."* (p11)

The notion of paid or Western foods was often the distinguishing factor between what constituted traditional foods and what did not. It was clear from most of the participants how the two ways of eating were different. A participant recalled eating wild game, certain harvested

foods and fish: *“We ate more what you call it wild meat. I remember eating corn, turnips of course potatoes, fish.”* (P2)

Another one shared how food was stored and how they would eat moose meat in the winter time:

“And then in the fall, and that was another thing, it was hard to keep that and what they used to have was they’d cut ice at the lake and uh, and then they’d keep sawdust and that and they’d have a little shed and then that’s where the meat would hang eh, even moose meat in the winter time eh, all winter and that’s how we were fed”. (P3)

With the exception to the reference to pork, another participant provided numerous examples of foods that had come from the bush: *“She boiled rabbits and pork meat...she would maybe stuff a duck and put it in the oven. Ya and we ate fish too, ya a lot of fish we had too...we lived right in the right in the little town and were able to just walk out in the bush and get, ya. Even I would go um snare rabbits and stuff like that...”* (P11)

Like many others, participant shared how they had lived off of wild game: *“I lived on deer and you know moose and all that.”* (P15)

And, *“Like cause when we like you know what, we ate a lot of rabbit, we ate lots of uh deer meat, that was our you know fish. Like you know they got fish like spring of the year, they got fish.... and if we didn’t have no meat like my dad would go out and get meat.”* (P19)

In addition to examples of traditional foods, several of the participants reminisced about the method in which food were traditionally prepared. Boiling was often mentioned and seemed to be a popular and often preferred method of cooking foods in the past. For example a participant shared: *“When my parents were raising us, everything was boiled. Like it was boiled*

on top of the stove nothing was ever in the oven, was everything was boiled, potatoes were boiled, the meats were boiled. That's how we ate, nothing was ever fried.” (P6)

Similarly participants also shared how boiling was a common way of preparing food when they were growing up: “*Well we had boiled, boiled rabbits and partridge, stuff like that.*” (P9) And “*Ya we used to have always boiled food, boiled dinners.*” (P15)

The idea that boiling was somehow better than frying was a common theme but this no longer seemed to be commonly practiced. For example one participant shared the traditional way of cooking food through boiling was no longer welcomed by some of her family members even though she would have preferred to keep up this traditional method of cooking:

Like my grandkids like it. But my own kid they won't bother and my husband doesn't like it either. He doesn't care too much for it but well I would say “I'm gonna make a boiled dinner.” Well my daughter, she just loves it. The rest the other ones no but I mean I give it to my husband, he eats it anyway. But it just I, I cook that way all the time, if I had the opportunity by just boiling it and cooking it with um, anything. (P12)

It became evident that most of the participants who referred to the past practice of boiling their food were viewed as a better or perhaps healthier way of preparing and consuming foods. This method was often contrasted with modern day practices of frying foods which most seemed to agree were likely not the best option.

Not all of the participants had been raised having had access to the land or wild game. Nevertheless some had been able to find other ways to access what might be considered more traditional foods through relying on others. For example one participant shared that growing up her family was able to access wild game and incorporate it into their diet by purchasing it. This

however did come at a price beyond financial. It came at the cost of being compared to white people: *“We use to eat a lot of rabbit at home and partridge and fish. And kind of, and none of my families weren’t hunters. My mom would always buy a rabbit ... because my brothers, 7 of them, weren’t hunters. (laughs) They were in the, they use to say, say to us, “You live like the white people.”(P13)*

There did not always seem to be agreement amongst the participants as to what constituted traditional foods or ways of eating. For example some of the participants considered wild game and fish as representing traditional foods while others also included harvested foods such as potatoes, carrots, turnip etc... which in reviewing the literature were not necessarily considered to be foods traditionally consumed by Aboriginal peoples but rather foods that had been introduced by the Europeans.

Many of these foods had become part of the ‘traditional’ diet over the last few centuries and this is likely the reason that for some they were considered as traditional. Therefore the definition or meaning of traditional seemed to vary among the participants. Wild game such as deer, moose, beaver and fish seemed to consistently be viewed by most if not all of the participants as traditional foods. Not all of the participants used the term traditional food but rather made reference to wild game or ‘the way we used to eat’ for example: *“We ate a lot of wild meat when we were young.” (P8)*

It was clear that what constituted as traditional foods was quite varied amongst the participants. There was no clear consensus on what constituted traditional foods. The reasons for these varied interpretations were likely associated with many factors including past experiences and proximity to the land growing up. A participant offered a unique perspective by questioning

the notion of traditional food altogether. When addressing traditional foods she suggested that the food itself was not important when it came to tradition but rather it was the act of gathering and sharing with one another:

“But people think, oh, traditional people, oh, like you know, uh one time my sister bought, there was somebody had died and she bought stuff, oh, we’re having a traditional meal here. So my sister said oh, so when did all the fruit become traditional? You know, she said like, you give what you can, like you know, like we made soup and sandwiches and everything like you know, lots of stuff and bringing it over like, if you, if you don’t you know like, how can you tell from what what is traditional and what’s not? You know, so I mean just the giving is is a, is myself, I think traditional is giving.” (P19)

Similarly participant also seemed to challenge the idea of what represented traditional foods. In his example he mentions wild game but presents it in a modern format making reference to burgers which most would likely agree is a Western concept: “You know. Pow wow food. Yea. And dumplings, you know. If they had rabbit stew you know, and if they had uh, real burger, well I mean like real moose burger and deer burger or, or any kind of burger like that, then I would say they were traditional food...” (9)

Many of the participants seemed to incorporate Western notions and ways when it came to their representation and interpretation of traditional foods or ways of eating. This clearly demonstrated the extent to which their ways of eating had not only been changed but how they had been influenced by Western ways.

The perception of having becoming lazy and no longer having to rely on the land was also present for several of the participants. Embracing the modern conveniences of jumping into

your car and going to the grocery store to buy what you needed was much easier than having to go out into the bush to hunt or fish or garden. Some of the participants even talked about linking reliance on the land with being poor whereas others viewed being able to access market or Western foods as a sign of affluence or being able to afford these “luxuries”. This was contrasted with those who shared that living off the land was actually simpler and easier and certainly more affordable.

Many of the participants were able to recount a diet that had been made up of things that had been grown or gathered from the land as well as hunted or through fishing however for many this way of accessing food seemed to have changed or no longer existed. Some of the participants had not had the opportunity to learn to live off the land and as a result seemed to be disconnected from that way of living. Others seemed to question the notion of traditional foods altogether and suggested that the act of sharing and gathering was in fact what was considered traditional and not necessarily the food itself. Much of the discourse around traditional foods and ways of eating interestingly seemed to be presented in the past tense.

None of the 22 participants who participated in this study had had the experience of being raised exclusively on a traditional diet or wild game. While some of the participants seemed to have been raised with traditional foods and wild game as accounting for a larger part of their diets, especially during the spring, summer or fall, they still incorporated what would be considered to be introduced or Western foods in their diets. At the opposite end of the continuum, some of the participants shared that they had not been raised consuming traditional foods or wild game at all either because their families were not hunters or they did not live in close enough proximity to be able to ‘live off the land’.

What became clear was that access to and the consumption of traditional foods or ways of eating seemed to be changing for many and in some cases may no longer be occurring. The more connected the participant appeared to be with their culture the more likely they were to continue to have some reliance on the land and traditional foods such as wild game while the participants who seemed the most disconnected with the culture were more likely to select and prefer Western ways of eating. This outcome of no longer exclusively relying on the land for many of the participants was conceptualized as becoming disconnected from the culture and the land and represents the second property of *changing ways of eating*.

4.2 *Disconnecting from the culture and land*

While a connection was made between culture and living off the land, it became apparent that over the course of time, this connection seemed to be changing and in some cases perhaps no longer existed for some of the participants. As the participants moved from the past into the present it became apparent that the changing ways when it came to food acquisition and consumption seemed to be demonstrating a form of disconnection from traditional ways especially when it came to eating.

The property of disconnecting from the culture and land seemed to emerge amidst the discourse surrounding giving meaning to the culture. A number of participants seemed to be demonstrating this form of disconnection in the form of having difficulty explaining what their culture meant or represented for them. Unlike some of the participants who seemed to be more connected with their culture. One Participant seemed to have difficulty putting into words what culture meant for him: “*I don’t know, just powwows and powwows...that’s it, you got your culture...*” (P16) This participant had made it clear at the outset of the interview that he was a

Christian by stating: *“First of all, number one feeling from now on is we always ask our Lord and Saviour for help...that’s number one.”* (P16)

This statement appeared to set the context for the entire interview and often his responses seemed to be guided by his strong belief system and his apparent disconnection from his culture. Several other participants shared similar beliefs and ultimately appeared to be more disconnected from their culture. Their religious often Christian upbringings appeared to have a strong influence over how they viewed themselves and to what extent culture played a role in their day to day lives. *“I was raised in the Catholic Church...so I became very Catholic...since then I have been learning about my own kind and I’ve come to experience and know our culture and spirituality and it’s beautiful.”* (P12) This participant’s excerpt provided a good example of how some of the participants had come to disconnect from their culture but in some cases were now beginning to reconnect.

A few of the participants seemed to struggle with the question of culture and at times were either unable to answer or provide an explanation of what it meant to them. Some of them attributed it to either parental or personal attendance at residential school while others provided no reason. For example one participant shared it was not something to which she gave much thought: *“I don’t think about it [culture] too much.”* (P2)

This participant had not attended residential school but had lived away from her community for a number of years only to return later in her life when she had decided to retire. By being removed from her community she had not been exposed to various practices such as living off the land and consuming traditional foods. Consequently she and many others who had

similar experiences seemed to have become disconnected from these cultural practices and beliefs.

Others related that even though they had been raised in their communities the reasons that they had not learned about their culture and more traditional ways such as living off the land and consuming traditional foods was attributed to the fact that in some cases their parents had attended residential school. For example another participant shared: “*Well, we were not taught any of the culture and I grew up here, on the reserve.*” (P12) Even though she had been raised and lived most of her life on the reserve the fact that her parents had attended residential school resulted in an upbringing that was absent of culture or traditions.

Those who had attended residential school themselves such as one participant also seemed to struggle to explain what culture represented for them. Although this participant was eventually able to provide some explanation she appeared to have difficulty likely as a result of herself having attended residential school. She was able to provide the example of attending a sweat lodge as an activity that she believed to be cultural: “I really can’t describe too much cause I was raised in a residential school...as far as going to my culture, I didn’t really see anybody or I did attend a few sweat lodges and that, which was good, but like the talk of tradition and all that, I just more or less go by what I seen on it, cause I wasn’t really into it”. (P18) Once again the lack of exposure to the culture growing up seemed to provide some explanation for this participant’s difficulty of putting it into words let alone being able to see a connection with living with diabetes.

While most of the participants viewed culture from a more positive perspective, a few of them were able to point out less positive aspects. These perspectives were also seen as likely

contributing to perpetuating a disconnection with culture and traditions for some of the participants. For example when addressing culture one participant suggested that the practice of looking out for one another which was practiced in the past no longer seemed to be happening. The idea of moving from a community to an individual focus seemed to be occurring: *“In the traditional times the adults always cared about the young people, they always, protected them from harm. I think um, Anishnabek people always, til very recently, always looked after each other. Now, just like everybody else, you’re just on your own.”* (P6) The idea of community over individuality is an important concept and teaching for Aboriginal peoples (Frideres and Gadacz, 2008). The fact that this traditional way of being seemed to be disappearing also provided some explanation of cultural disconnection that was being experienced by some of the participants. Similarly one participant suggested that the idea of sharing with one another was not as widely practiced as it once had been: *“Yeah well I guess they do but they go on hunting trip so they must be getting...I don’t know what they do with all the meat... Sure in the hell not sharing it.”* (P2) The concept of sharing which is closely associated with the notion of community seemed important for this participant and once again representing a factor that was likely contributing to cultural disconnection.

Another participant shared that for him his culture meant that he was separate from mainstream society: *“we’re more or less standing on the outside looking in.”*(P5) The context of this response was in relation to what he knew about his culture and what it meant to him. This response is representative of how he and many others feel as Aboriginal peoples. This participant went on to shed some light on what may have ultimately influenced his choices:

(...) it's the way um I guess my parents uh raised and taught me. Um, they made me go to school, um, and they made me get out of bed to go to school, you have to go to school, you can't stay home because if you stay home uh you won't be able to you know enjoy what's out there for yourself...My my dad worked for uh MNR for a number of years as a seasonal uh seasonal employment eh and then he was a trapper and as soon as he was done with MNR I guess from uh May til whenever October November he'd go up the uh trap line which is uh up the north. Anyway uh he'd stay up there and come out every month to go sell you know whatever um his uh harvest was and uh and he says you don't you don't want to live like that you know, go to school, get education.

(P 5)

This participant clearly demonstrated that he had actually been discouraged from living off the land and encouraged to become educated so that he could benefit from what the world had to offer.

In addition to religious beliefs there were many reasons provided as justification for the disconnection from the culture and land including changes in cultural practices and parental influence. This was ultimately conceptualized as disconnecting from the culture and the land. Three dimensions related to disconnecting from the culture and land were identified and consisted of rejecting traditional foods, depending on Western foods, and the notion of not being able to go back.

4.2.1 *Rejecting "traditional Foods"*

Many of the participants gave accounts of having been raised living off the land and eating traditional foods. Several of them had decided that they no longer wished to continue to

rely on these food sources for various reasons such as taste or a negative association between traditional foods and poverty. *“I can’t stand the taste of it anymore...I used to eat muskrat but now if I was to I would just look at it and think blah”*(P2). *“My parents were poor so we were raised on traditional food”* (P11).

Others had not had the opportunity to experience or been raised eating traditional foods and as a result had not incorporated things like wild game into their diets. *“You know we hear that all the time we never used to eat those foods...we lived off the land...well that wasn’t in my era...I never done that.”* (P 1) It appeared to be a conscious choice by some to stop consuming traditional foods such as wild game while others simply did not seem interested or had not been exposed. These choices were conceptualized as rejecting traditional foods.

For the participants who once had eaten wild game several were able to provide reasons or explanations as to why they no longer wished to eat these traditional foods, especially when it came to wild game. For example one participant shared how she no longer liked the taste of certain wild meats likely because her taste had changed:

“(...) like I used to eat moose meat before I can’t stand the taste of it anymore. ...you’re what you call it...your appetite for different foods changes or something...lose your taste buds I guess. At one time they used to eat muskrat around here . I used to eat that and now if I was too, I would just look at it and think blah hahaha (,,)” (P2) Similarly with another participant now refused to eat moose meat simply because she had eaten so much of it as a child: *“I won’t eat it [moose meat] now cause I had so much of it as a little girl.”* (P3)

Another participant also shared how she had grown sick of eating rabbit in particular because she had eaten so much of it growing up: *“... but we ate so much rabbit, uh, you know*

what, I was so sick of rabbit after I you know, I I just didn't care for rabbit no more cause we ate so much of it eh you know." (P19)

Another interesting perspective related to traditional foods that seemed to emerge for some of the participants was the idea that for some consuming traditional foods was done out of necessity. When referring to traditional foods, one participant provided a unique perspective by making a link between consuming traditional foods and being poor: *"I know, my parents were poor people too so, we were raised on traditional food, vegetables and stuff like that and mom would only boil them, she wouldn't fry them."*(P11) This stereotyping of traditional foods by some likely played a role in changing the ways that some of the participants ate and promoted a greater dependence on Western type foods.

Another interesting perspective that was shared by several of the participants appeared to emerge. As an example one participant seemed to imply that perhaps traditional foods were not as good in quality and that it was a way of life as a result of being poor. She went on to suggest that her diet was better now than it had been growing up:

"Well, like I don't I do eat better now cause we were poor growing up so my mom had to uh she had to eat a lot of wildlife, we ate a lot of wildlife, like she did her best for us but like lots of times you didn't even have food, we were starving but no, I eat good now." (P20)

While traditional foods seemed to represent lower quality for this participant it was also a source of shame that had led her to feel stigmatized as an Aboriginal person:

Well, I remember um for school wise... we didn't have any bread so my mom would be frying scone and um and sometimes you know, and to go to school like to get a take a lunch... I'd be ashamed to bring the scone out and eat it ... There would be times that I

wouldn't have no lunch uh til afterwards I was by myself and then and then I'd eat the scone ... I wish I was not ashamed to be an to be an Indian uh cause like I figured well I'm gonna be be like caught? (P20)

It was evident that the negative associations made between traditional foods and growing up poor played a significant role in changing the way she and many of the other participants now ate. This particular participant seemed ashamed to be Aboriginal.

For another participant it was now a matter of choice. As a child she did not have any other options however now she could eat what she wanted:

No, oh no, you don't catch me eating wild game no more... I just never did acquire a taste for it. Like, I had to eat it when I was small because that's what my parents put on the table, now that I have a choice of what I want to eat, I go out and buy it... those days I was, I had to eat what was put in front of me as a child. But now that I'm an adult I can have a choice of what I want... No, I never did like it.(P6)

Again for another participant it was also a matter of choice: *"You have a choice today, them days you didn't you know..."(P17)* These last two examples were also present for many other participants. The fact that there was now more choice available when it came to food selection was seen as a positive thing and appeared to contribute to rejecting what is considered to be more traditional forms of eating.

Similarly with one other participant shared how things have changed and how there was less choice in the past. Unlike participant 17, she went on to suggest how much things had changed but not necessarily for the better:

In those days there was no television and you'd sit and eat, we'd all eat together. Now today, you give a kid a plate, oh, I'm going to go in my bedroom, I'm gonna go eat or they'll turn on the tv and sit in front of the tv where in those days we didn't, we'd sit at the table and we'd eat what was put on the table. If you didn't eat it you were hungry, you went hungry because uh, you just, you just couldn't be fussy. You ate what was there and you didn't know the difference, there was no such a thing as McDonald's, you couldn't say, "Oh, I wish I had a hamburger instead of this". You didn't know the difference, you couldn't compare, you couldn't compare the food because it was only the very basic line of food and uh, and the way it was prepared was boiled and there was, it or baked. (P3)

In this last example, the participant seems to provide an explanation as to why traditional foods or ways of eating are less popular or in some cases being rejected especially by the younger generation who now are less restricted in their food choices.

Another participant seemed to suggest that rejecting traditional foods was attributed to not knowing how to prepare it: *"As far as it goes for uh, moose meat, I don't care for it. Maybe I don't know how to cook it. I find it tastes wild."* (P12) As noted in the property of being connected to the culture and land, there exist various interpretations of what constitutes traditional foods. Although the example provided by a participant did not consist of what might be considered by some as a typical traditional food or wild game, it was foreign to her granddaughter and provided yet another example of rejecting what some represented as more traditional types of foods: *"Well my granddaughter one day I had I had a like I had potatoes and carrots and turnips and I had pork hocks all in a big roast pan. Oh gram, gross, oh my*

God, I can't eat that, you know, like that's, you know. Oh my God gram, are youse eating? Oh ya, that's how we ate that.” (P19)

Several of the participants shared how they had been exposed to traditional ways of eating, often in the form of wild game but no longer incorporated these types of foods into their diets because of what some described as a changing palate or a growing dislike to simply now having a more choices when it comes to eating. While this was the case for some, others had never had the opportunity or exposure to this way of eating and consequently were not necessarily rejecting traditional foods or ways of eating but rather had simply come to depend on other sources of food.

4.2.2 Depending on “Western Foods”

While several of the participants had developed a dislike for certain traditional foods, others had not been raised or exposed to traditional foods and therefore had not acquired a taste or liking for these foods. There were various reasons provided as to why some of the participants had not had the opportunity to grow up eating traditional foods or wild game. Among these included having been raised outside of the community or in more urban centres or not having had acquired the skills to hunt or fish. This lack of exposure to traditional foods had led to a dependence on other sources of food which was conceptualized as depending on Western foods and formed the second dimension of the property of disconnecting from the culture and the land.

For one participant it was a matter of not having had the opportunity of being exposed to what he called “Native food” growing up that impacted whether or not traditional foods were incorporated into one’s diet: “Probably because their children don’t like um Native food. They haven’t uh tasted it before and when they do taste it uh, ewww, I don’t like that, tastes don’t taste

good they say. My son don't like Native food ...my son didn't grow up with that in his time...he likes the European food.” (P11)

This also seemed to be the case for another participant who shared that before her time there had been more reliance on traditional food sources however this had not been the case for her: *“So before my time, I never really ate those things. But it was a lot of hunted meat... Their groceries were once a month. When I was growing up it was once a month. My grandparents would go get groceries.”* (P7)

This last excerpt represented a classic example that explained why some of the participants had not grown to either acquire a taste for or a desire to consume more traditional foods. They simply had not been raised or exposed to this way of eating. Similarly with another participant also shared how she had not been raised on wild game and goes went on to provide an example of foods that although she may have considered being traditional would be considered Western foods:

“Now I'm not, I hadn't been raised on moose meat or anything like that. My dad worked at the steel plant so a lot of the other families always had that...you know the moose meat...I was just raised on store bought food so for me it wasn't uh, difficulty or anything like that. My grandpa use to make um, stews out of chicken with cabbage and carrots and potatoes and of course he'd put in salt pork and uh, he'd make chicken stew like that and it was all boiled and I loved it...” (P12)

For others the reliance on Western foods had developed out of necessity because they did not have access to all of the foods they required simply from living off the land. As a result, and as demonstrated by one participant, you had to go and buy food off the shelves: *“(...) maybe uh*

the only product we would buy outside what they were farming was uh like of course not all of us had you know the livestock, go out and buy a lot of stuff that's on the shelves and that's in the market." (P5)

The notion of convenience and ease fared prominently in the reasons cited for an increasing reliance on Western foods and ways of eating. For example one participant shared how access to food and the preparation was so much simpler today:

Well the convenience eh? The store, the store's there, you don't, and we, we don't have no more gardens ... Well, it's more comfortable for a person when you don't have to worry about uh, preparing it and that's another thing, that's a lazy way out. You don't have to worry about preparing it the way they did in the olden days, how it was prepared, now it's so much easier. There's microwave, you throw it in there, and it's so much easier. (P3)

Similarly with another participant also seemed to embrace the conveniences of Western foods: *"(...) Well there's lot of can stuff and you know everything is canned, canned goods everything's packaged. Like even the meats are packaged now, like they (...) All the foods that are canned and it's so easy to you know open up something, quick meal."* (P4)

For one participant it was simply a question of having become lazy. Accessing Western foods took a lot less effort: *"Now it's just run to town and get your stuff out of the store like it's not like go hunt and fish for...I used to hunt too and everything and I don't even do it any more so I don't know, it's just lazy you know, everything's too easy, easy access just to run to the store and go and grab instead of going to work for it."* (P14)

For another participant relying on Western foods had also become a choice not only born out of convenience but perhaps even out of necessity since it appeared to be too difficult or require too much energy to do otherwise:

Because um for them for people to go out and say to shoot a moose or to shoot a deer, um a lot of a lot of people today have to get a gun license, have to have a uh certain place to shoot their game whereas when I was a little girl my father would go in [place] to there was a big area I guess and uh he always he'd always go with members of my family uh of his family, his uh brothers, and they'd be gone all day and uh at night usually they'd come home with a deer or a moose or uh whereas today they'd sooner go to town and go buy a pound of uh of hamburger, a pound of roast beef instead...(P20)

Once again the contrast between the past and the present was evident in this last excerpt. This provided yet another clear example of how changing ways had led to changing ways of eating.

For one participant the new reliance on Western foods was simply the way things had evolved for this new generation: “(...) *younger people they don't live off the land like now, whereas we did in those days (...) it's a different generation again from when I was 15.*” (P3) This seemed to imply that changing ways of eating has naturally occurred over time and had now become the new or accepted norm for many.

For another participant having to rely on Western foods had resulted from not having had the necessary skills to do otherwise or perhaps even as a result of simply not being interested in the old ways of doing things:

Uh, I don't know, probably because we live in the city now and have a, it's hard for some young people to get uh, out in the bush to hunt and they don't know how to hunt ... there was no hunting experiences and well, I think because uh they don't have guns or hard time to get guns and people aren't, some of them live on uh low incomes and no vehicles to get out to go hunting and they uh, just, not interested in it anymore. (P11)

Once again there seemed to be a sense of resignation to the way things had evolved and changed. The lack of having acquired the necessary skills to live or rely off the land did not seem to be a source of concern but rather just a matter of course which ultimately translated into a loss of interest. This view was shared by several of the participants.

The notion of having had new foods introduced was addressed by one participant who provided concrete examples of food sources that had been “brought over”: *“(...) even then the flour, we use to eat a lot of flour. Which is scone but that's part, that's not the Native food you, they because that was brought over, those white foods, like lard, flour, sugar, salt. They're all brought over but we use to make scone out of those, dumplings, and you know...In my generation it was all the flours, sugars.” (P7)*

One participant seemed to suggest that the reliance on Western foods not only had been imposed on Aboriginal people but that this imposition came with consequences:

“I know Natives are really, the majority of them were diabetes but what I've been hearing is that long time ago we ate off the land and the government brought in welfare and all that, that's why we're all, all of a sudden diabetic and all that and sugar and salt and everything like that eh ...It's just basically what they brought to us and we

were kind of forced to eat it or we live the hard way and rather than going hunting everything's handed to you so take it then (...)" (P18)

In this last statement an important idea seems to have emerged and that is that prior to the introduction of welfare people had to rely on the land and as a result of its introduction a form of dependency occurred which likely contributed to the disconnection or decreased reliance on the land.

Similarly another participant recounted how the introduction of new foods had led to a reliance and loss of control: *"The French came...the English. I know they had maple. We used to use but ahh other than the berries. But all of sudden they had pies and...Anyways I guess it was good but we didn't know how to control ourselves like...eating all these ahh foods...taste good so you got to have lots."* (P2)

There were several reasons provided to explain why many had come to rely more on Western foods and less so on traditional foods. These included not having been exposed to traditional foods growing up because their father was not a hunter, appreciating the convenience of access and having this new way of eating imposed.

This decrease on relying on the land had led to adopting new ways of accessing foods. Once again a contrast between the past and the present was often made. Since many no longer relied on or accessed the land for their food, the new ways of acquiring food were explained and in some cases justified. For example one participant shared that unlike in the past when hunting was relied upon, individuals could now simply jump in their cars and get what they needed from a grocery store: *"... well now you jump in your car and go to the grocery store and get your food. Years ago you had to ahh your father had to be a hunter."* (P2)

For another participant the new ways of accessing food meant that there was no longer an exclusive reliance on the bush but that other foods which were often purchased had been added to the diet: *“Uh, even as a young lad I can remember, like uh, always in the bush. Like rabbits, hunting rabbits. Even like partridge. We always ate uh, wild meat eh. But now, like it’s whatever eh. Like beef and pork, chicken.”* (P8)

Finally for one participant it was simply because today people have money and can simply to and buy their food as opposed to accessing it other ways: *“... today like you get money and you go to grocery store and buy all your stuff.”* (P17)

What emerged from the interviews was that ways of eating including traditional foods and wild game had changed as a result of European contact and colonial impact which had ultimately resulted in a forced assimilation. Although this was the case or perception for some of the participants what I discovered was that others were glad that they no longer had to eat wild game which they had come to dislike. They were embracing the increased food choices and selection and seemed to willingly be incorporating the new ways of eating and foods into their daily diets.

For some of the participants a link between their representation of culture and traditional foods was ever present. However for others there was no apparent link between culture and eating. This seemed to particularly be the case for those who had been raised in what might be considered to be less traditional homes in which dependence was more on market foods than on wild game or other forms of traditional foods.

Racialized assumptions could be made which suggest that simply by the virtue of being an Aboriginal person, one has been raised to live off the land and traditional ways of eating. To

do so would be to suggest that culture is static and that there is only one way that one can be Aboriginal or seen as traditional. As was demonstrated through several of the participants of this study, this is not always the case. Participants who had incorporated ‘newer’ ways of eating did not necessarily feel disconnected from their culture. Disconnection from one’s culture and ways of doing things can occur when individuals are removed from their communities in order to attend residential school or as a result of developing a negative view of traditional practices and beliefs. The ensuing disconnection can result in changing the ways in which some Aboriginal peoples acquire and consume their food. This can ultimately lead to or be perceived as being the cause of increased numbers of people living with diabetes.

The notion of living between two worlds seemed ever present for several of the participants. This idea was best captured by a statement made by one participant who shared: *“I’d like to kinda think of myself walking around with a moccasin in one foot and a tennis shoe in the other. You know you still have that simplicity but you’re still living in the world that it is today.” (P1)*

For some this meant still being and wanting to be connected to the land while embracing and welcoming the modern conveniences while for others it seemed more of a forced imposition, that is, they were no longer able to rely exclusively on the land even if they wanted to either because they did not have the access, skills or resources to do so. This new way of living was now the reality and ultimately there was really no other choice but to adapt.

In this section I provided a number of examples and ways in which some of the participants demonstrated a disconnection from the culture and land. In most cases this disconnection appeared to be a conscious and deliberate choice while for others it seemed to

have been imposed. It presented as a rejection of traditional foods for some and the subsequent development of a reliance on market food for others. Ultimately this presented as having adopted new ways of accessing food. In the next section I will present how this disconnection from the culture and land has led to changing ways for the participants in this study.

4.2.3 *No going back*

Although the way in which food acquisition and consumption has changed for many of the participants it was not always necessarily seen as a negative thing, in spite of the fact that as noted in the previous sections these changes were often seen as having been imposed. Throughout the discourse on eating which often presented a contrast between then and now it appeared as though the changing ways of eating actually seemed to be welcomed if not embraced by several if not most of the participants.

The notion of not being able to go back to the way things were seemed to reoccur frequently during the course of several of the interviews. Often this was linked to the idea that things and times had changed to a point where it was either no longer feasible or even realistic to expect things to return to the way they once had been. This was often in the context of the culture in general but more so specifically in relation to the way food is acquired and consumed. Living off the land and relying on wild game or other traditional foods did not seem realistic for some or even possible for others. Ultimately this was conceptualized as no going back.

For example for one participant it was a matter of having embraced all of the modern conveniences that made it impossible to return to the old or traditional ways:

We'd, we as Native people would notice a lot of difference. I'm just going by speaking to our people and they wanna live our way of life. You know, then there's a lot of them

that want to go back the way, the way it was but we can't go back there. Where all, where all living in homes here, we got power, running water, showers, baths everything. Shopping in the city and you talk about going back. I, I don't think anybody wants to be living in a teepee anymore, you know. And hunting of the land, they hunt, they fish. They do all that but that's the, that's the difference there. That is, they, they don't want the white world, they want their own ways of life but then again they don't wanna go back there. (P13)

It appeared that for some, as illustrated above, there is an ensuing internal conflict about reconciling the old with the new ways of doing things, in this case when it comes to eating. This participant seems to suggest that some Aboriginal peoples want to have it both ways. He appears to be suggesting that this is not possible. What this excerpt is possibly illustrating is that it's not a question of old versus new but perhaps simply a new way of doing things.

Conversely for one participant there seemed to be the suggestion that returning to the "other" way can't occur once new ways of eating are adopted: *"Everybody, even your kids, say oh, well can we have spaghetti or can we have pizza or you know? So like that's you know, it just it just came about and then everybody picked up on it right away and oh I'm not gonna eat the other way."* (P19)

This last example provided a clear illustration of how for some at least, there is no going back to the way things were. Finally another participant seemed to suggest that ultimately it may not be a matter of choice but rather one of having to adapt: *"Well, it's hard to change, everything is so commercialized eh, everything is, you go with the flow."* (P3)

This perception was not an uncommon one amongst the participants. There appeared to be a sense of resignation to adopting new ways of eating if not out of obligation perhaps even out of necessity. Unlike one participant (#13) who seemed to suggest that adapting to new ways did not necessarily mean having to abandon old ways of doing things, this last perspective seemed to imply that it may be futile to try and hang on to the past. The notion of not having any control appears to be present in some of the participants discourse thereby providing an explanation for why some of them have simply resigned themselves to a new way of eating at the cost of abandoning or ignoring more traditional ways which were often viewed as healthier. This point was well illustrated by one participant who suggested that prior to contact, when there was a reliance on the land, diabetes did not exist:

So the impact of...of colonization all that stuff really did have an impact on...on what we eat... but when I think about our culture, you know our culture; we can't go back to the way that our culture was. When it was when we didn't have diabetes. You know we hear that all the time that, ohh we never used to eat those fatty foods and you know Our food was never like that or we lived off the land. (P1)

Once again the notion of not being able to go back was prominent in this excerpt. What was particularly striking in this account was the perception that even though the 'old ways' were likely better and tended to not be associated with diabetes, for this participant as well as several others, it just was not possible to return to that time. Once again the sense of having to adapt or acquiesce to the new ways was ever present. There was a sense of having been defeated which was repeatedly conceptualized by several of the participants as not being able to go back even if one wanted to.

In the preceding section I presented the findings related to what was conceptualized as disconnecting from the culture and the land. Three dimensions including a rejection of traditional ways, depending on Western ways, and the notion of no going back were also presented. Most of the participants seem to demonstrate to some extent either a partial or in some cases complete disconnection with their culture and the land. There were various ways in which this disconnection was demonstrated.

This section also explored the various ways in which the participants represented the changing ways in which they acquired and consumed their foods. They often provided a contrast between the way things once were and how over time ways of acquiring and consuming food had been adapted and ultimately changed. A link was made by several of the participants between these changes and adaptation and the increasing incidence of diabetes in their communities.

4.3 *Summary*

This chapter presented the first part of the findings from the data analysis of this research study. Throughout the participant interviews various terms were employed to distinguish between what was considered ‘traditional’ foods or ways of eating and introduced ways. Participants used words like traditional, native and even ‘Pow Wow’ foods when referring to what they believed to be a more ‘typical’ Aboriginal diet. When talking about foods that had not been part of the traditional Aboriginal diet or introduced they would use terms like white, European or Western foods. There seemed to be no consistent terminology used to describe or represent either way of eating. What was consistent was the fact that most of the participants had developed a language to allow them to make the distinction.

Data which consisted of transcript excerpts were used to explain and illustrate the two main properties associated with changing ways of eating which included being connected to the land and culture and disconnecting from the land and culture. The various dimensions for each of these properties were also presented and illustrated with data from the participant interviews which were used as a form of validation of the conceptualizations that were ultimately presented. The participants provided an explanation that seemed to justify how over time their ways of eating had changed. The notion of being connected to the land was demonstrated by giving meaning to their culture, explanations of living off the land and providing examples of what was considered as ‘traditional’ foods. It appeared that some of the participants appeared more connected to their culture and land than others while others appeared to be disconnecting. This form of disconnection was ultimately demonstrated through examples of how traditional ways of eating were being rejected by some in favor of adopting a more European or Western diet. For several of the participants at least the notion of not being able to go back to the traditional ways of eating and living of the land seemed inevitable for some and a matter of choice for others.

In Chapter Five I will present the findings related to the category of ‘*developing diabetes*’ as represented by the participants in this study.

CHAPTER FIVE

DEVELOPING DIABETES

This findings chapter will present the second emergent category which was eventually named '*developing diabetes*'. This category emerged in response to the participants' explanations of how they had come to develop diabetes which included personal theories of causation often linked to changing ways of eating as well as what diabetes meant for them. Initially some of the responses that were elicited might be considered quite typical for anyone living with type II diabetes. For example one participant shared: "*The eating part is the most difficult part of all.*" (P 19)

Individuals living with diabetes are likely to share that having to watch their diet or change the way they eat is one of the most challenging aspects of living with diabetes. This would not be any different for Aboriginal peoples. In order to gain a better appreciation of how the experience might be different for Aboriginal peoples it was necessary to avoid asking questions that might elicit typical responses around the challenges of living with diabetes. What began to emerge was the perceived connection between ways of eating and diabetes being made by the participants themselves.

By delving further into the responses it became evident that what was being said extended beyond classic representations of living with diabetes and included depictions that seemed more specific to Aboriginal peoples who have been colonized and the many ways in which this has impacted their lives and perhaps even contributed to the development of diabetes. This perspective was especially evident in the following participant's narrative:

(...)I'm talking about in the 1400s when the European contact, we were set up, uh we were a very modern society, uh we live our life, we I guess we had some sort of a government setup, where each tribe or each nation honoured the other nations you know traditions and cultures and everything so everyone they would share that but uh when European contact was made uh that was all disrupted all you know we're we're getting to be more uh commercialized I would say again and breaking away from our traditions...so to me it's the way you live, just because your parents have diabetes doesn't mean you have to have diabetes...it's the way we live I would say, it's up to you to prevent it (P 5).

For this participant a clear link was made between diabetes and the many disruptions that have impacted Aboriginal peoples and a rejection of the common perception shared by many participants that diabetes was passed down from the generations. This provides a great example of the colonial impact of European contact on the development of diabetes through the eyes of this participant. It was through this lens and through constant comparison as well as always remaining close to the original research question which was seeking to explore how colonization has impacted the experience of living with type II diabetes for Aboriginal peoples living along the North Shore of Lake Huron that representations and meanings were elicited.

The discourse surrounding diabetes took an interesting and often consistent trajectory. There were several questions that prompted the participants to begin sharing and discussing what diabetes either meant or represented for them. These ranged from general questions such as simply asking them to explain what diabetes meant for them to questions about particular culturally related challenges that they might face. Participants would invariably begin by sharing

how they had anticipated or expected to develop diabetes at some point in their lives and would go on to talk about how they saw a link between how their changing ways of eating may have contributed to developing diabetes. These two areas were eventually identified as the properties of the category of '*developing diabetes*'. The following section will provide a detailed description of the two properties and associated dimensions related to this second category.

5.1 *Inevitable outcome*

The first property related to *living with diabetes* was conceptualized as an *inevitable outcome*. It became evident throughout most of the interviews that the participants often expected that someday they would develop type II diabetes. For example the notion of inevitability was shared by the following two participants: "*They said I might get it [diabetes] when I'm 45 and I did get it. So I wasn't too shocked with it*" (P 11). And: "*Well at first I was just like oh no, here we go and then I was looking back on my mother and then my grandmother and that's how they got it so I was thinking oh oh you know. It's inevitable I guess you'd say like it's just like oh oh here we go.*" (P 14).

The fact that diabetes seemed an inevitable fate or inescapable destiny for most of the participants was ever present throughout most of the interviews. Most if not all had expected to eventually become 'diabetic'. As with most illnesses or conditions there is always a tendency to want to attribute blame or identify a cause. In the literature this is often referred to as theories of causation. This was no different for the participants in this study.

What eventually emerged were two varying yet distinct perspectives on why they believed they had developed type II diabetes: i) it had been imposed or passed down to them; or ii) it had developed as a result of something that they had done or failed to do at some point in

their lives. For some of the participants there appeared to be elements of both as contributing to the development of diabetes. These two perspectives formed the dimensions of the property *inevitable outcome* and included *generational and cultural changes*, and *lifestyle changes*. In the next section the two dimensions of inevitable outcome will be illustrated with data from the participant interviews.

5.1.1 *Genetics and culture*

The first dimension of inevitable outcome was the idea that diabetes was something that had been passed down to them. “(...) *it all goes back to the parents, if they have diabetes in their life, it's usually passed down generation to generation... so it was bound to get me which it did.*” (P 18). There were various reasons cited by the participants explaining why they believed that they had developed diabetes that included a genetic predisposition, as a result of their culture or in one case imposed by God in the Christian sense rather than God the Creator from the Traditional sense. The idea that diabetes was inherited recurred frequently. For example one participant shared that: “(...) *well its hereditary ahh I believe that's what it is and my...my father had it and my mother has it ...my father had it, my grandfather had it...no doubt my kids will probably get it.*” (P 4) It was obvious from this participants' account that diabetes had impacted several members of his family and he even anticipated the fate for his children.

Not surprisingly the extent to which diabetes was present in the participant's families was often mentioned: “*my older siblings, they all have diabetes, my mother had diabetes, my father was a diabetic.*” (P 5) And: “*I have aunts, I, my aunt is a diabetic, my sister's a diabetic, we're all diabetics.*” (P 7) The extent of diabetes in this last participant's account was quite remarkable. She seemed to imply that her entire family had diabetes. The way in which she made this

declaration was also interesting because it was presented in such a matter of fact way perhaps suggesting that this was completely normal.

Some of the participants came to discover that they were not alone and that many of their family members eventually disclosed the illness as well:

“its after I got it that it started to come out. My sister had diabetes and I got one sister left so she’s got diabetes as well.” (P 10) The idea of not being the only one to have diabetes suggested that they were in good company: *“I’m in good company.”* (P 11)

Most of the participants seemed to view diabetes as something that you eventually inherit. This perception is what led to the conceptualization that for most of the participants in this study, diabetes was an inevitable and perhaps even inescapable fate that awaited most of them at some point in their lives.

In addition to attributing their diabetes to genetics many of the participants also believed that diabetes had developed as a result of various changes that occurred in their culture in terms of ways of living and eating. The following participant exemplified this perspective through the following: *“All this, all this bad stuff brought into us. We were healthy growing up at home and now all the, I don’t know, all the different foods I guess. We were healthy growing up but not healthy enough I guess. (chuckle) My dad was diabetic too.”* (P 13)

In the previous chapter changes in cultural practices as a way of linking changing ways of eating to the development of diabetes. In this context the sense that diabetes had been inflicted upon them as a result of cultural changes and disruption also seemed to emerge. In another example one of the participants attributed diabetes to having lost the simple ways of living:

We started getting sick...you know people lost their legs and they lost their vision and their liver and all the effects of diabetes...They [Europeans] took the simpleness out of life...new ways of living were introduced to us...it's the white people...and we as Aboriginal people had to live and survive living with the white people...when something is introduced you are intrigued by it...everybody wants more. (P1)

This participant appears to be suggesting that the new ways of living, which were imposed on Aboriginal peoples by the Europeans, led to diabetes and its related complications. She went on to imply that Aboriginal people had to change their ways if they wanted to survive. This imposition, which was eventually adopted, had perhaps led to overindulgence that did not seem to exist when life was simpler.

Similarly another participant seemed to

link being Aboriginal with the development of diabetes: *"I think that, well you know like ahh you watch TV and certainly mostly the natives that are getting the diabetes...but there's certain already...already happening in the white world too like...I don't know what's the cause."* (P 4)

Although not exactly certain of the cause this participant seemed aware that diabetes was perhaps more prevalent in Aboriginal peoples while at the same time questioning to what extent it was impacting white people. The idea of questioning recurred frequently:

I don't know if it's only Native, not only Natives have diabetes I don't think. I think it's world renowned disease eh." (P 3) And: *"(...) then like I started reading and then*

talking about the Indians having more diabetes and I wonder why?"(P 8) And also:

"I'm not sure how the mainstream non-Native society and you know uh they're a bigger

population, uh you know we're probably outnumbered as far as population is concerned uh but we're uh it seems like be because we're a small minority group in Canada and lot of us uh are destined to be diabetics. (P 5)

Although uncertain of the reasons the idea that Aboriginal peoples were 'destined to be diabetics' was at the core of this last participant's statement. She also appeared to question why diabetes did not seem to be affecting 'non-Natives' to the same extent.

The fact that diabetes had become more prevalent was often encountered. For example one participant shared: *"A long time ago there was no diabetes...I remember the first time I heard somebody had diabetes. I still remember that, she was the first one, you know she's diabetic and everybody talked about it because she was diabetic..Nowadays it's anybody you talk to."* (P 17)

Several of the participants seemed to question the reasons for the problem of diabetes while at the same time realizing its prevalence amongst Aboriginal peoples. While some of them simply made a link to their ethnicity others were able to elaborate further on why this might be the case. For this participant the notion of being unique seemed to provide an explanation:

I hear it every place, I hear it on the news, that uh, uh Aboriginal people are more prone to suffering from the disease... the way I see it is um, um, I think um, we're, we're a unique people, in um, in this world. I think we're very unique people ... some of the things I hear there for some of the things I hear from the leaders um, is uh, we're different, uh we have um, um, different metabolism ... we live our life differently as opposed to the mainstream society, um, we're more culturally uh oriented, uh um, I guess meaning like trying to live off Mother Earth and stuff like that and um, and um,

and um, you know when you go to a grocery store, you know you buy this, you buy that and then nobody reads the label on the, on on the, any of the products so what you do is you consume and now when I said culturally oriented we, we do hunt and fish you know. We, we uh, we depend on some of the uh what's provided for us so when uh, when you mix everything together you uh, you know, it doesn't balance out. (P 5)

The essence of what this participant was sharing was that he believed that, in his opinion, Aboriginal people had not been designed to live the way Europeans do and that the imposition of this new way of living ultimately led to an imbalance. This last example could possibly represent the internalization by this participant of the colonial construction of Aboriginal peoples, that is, that somehow Aboriginal peoples are genetically inferior and their bodies are not suited for modernization.

Perhaps one of the most interesting and original ideas was presented by the following participant who believed that for her at least, diabetes had been 'inflicted' upon her by God because of a lack of balance in her life: *"you know diabetes really is a teacher in itself to us as human beings, directly to balance of life, balance our food and balance our strengths you know with our weaknesses and um for me I believe it, I think the good Lord gave me diabetes because (laughs) they could see an imbalance there."* (P 12)

In spite of the fact that several of the participants in this study self-identified as having a strong Christian faith she was the only one that not only attributed her developing diabetes to God but somehow seemed to welcome it. The fact that she was not living in balance had led to developing diabetes.

Another example of the perception that somehow Aboriginal people were different and not ‘made’ to live the way they now did was provided by the following participant: *“Cause is our body made up differently from the other people? You know what I mean? Like, we can’t absorb all these uh you know, additives properly.”* (P 15)

Many of the participants appeared to suggest that the reason that so many Aboriginal peoples were now developing diabetes was that the imposition of new ways of not only eating but of living in general had been imposed upon the culture. This imposition was ultimately responsible for the inevitability of Aboriginal peoples developing diabetes.

For yet another participant the cultural dimension included the role of the elders and how the ever increasing absence of elder’s guidance may have contributed to increasing rates of illness including diabetes in Aboriginal peoples:

Well I think in like, in the old times, in the old ways when, at the time of my dad, I’ll use my dad and my mom, they always had elders behind them eh. There was always elders advising the young people what to do, advising the young parents of what to do. But now, we don’t have that much elders advising us in anything or the elders themselves just don’t really care no more. In order to lead the good life you have to have somebody advising you where to go, just like parents all the time. Parents are always watching over their children, if you do wrong then they sit you back on that straight road you’re supposed to be walking on. (P 6)

It was clear for this participant that the loss of the elder’s role in Aboriginal culture was perhaps one of the elements that was responsible for inflicting sickness as a result of not having learned

to live the good life. The reason cited for the loss of elders was directly attributed to residential school attendance and ultimate loss of traditions and practices.

Residential school came in. You know, I find once you were removed from your home, where security was and you were put into a world that you did not understand, I think you lost a lot of stuff in between. Like and that's where the teachings of everything went lost for the Anishnabek people and when they did come back, well, they, they did not understand the Anishnabe way no more, or they didn't want to cause they were, if you practiced your traditional way once you got into that residential school while you were punished for it. And by the time that everything shut down, well you didn't care no more because all the length of time that you were in residential school, you knew you were going to be punished for that so in that process you just let go of everything and, and some people, Anishnabek people never came back to it. (P 6)

For this last participant it was inevitable that people are now becoming sick.

In the preceding section a number of examples were provided that appeared to suggest that developing diabetes was inevitable because of various factors which had been imposed through genetics or inflicted through cultural disruptions upon Aboriginal peoples. While this perspective was quite common the idea that somehow individuals themselves were responsible for developing diabetes as a result of changes in lifestyle also seemed to emerge.

5.1.2 *Lifestyle changes*

The second dimension of inevitable outcome was the idea that changes in lifestyle were also somehow responsible for developing diabetes. There were various reasons cited by the participants explaining why they believed that lifestyle changes had contributed to diabetes.

What was particularly interesting was the fact that many of the participants recognized that while on the one hand individuals are ultimately responsible for lifestyle choices many of the changes that had occurred were perhaps not of their own doing and had actually been imposed upon them as a result of European contact. For example one participant shared that:

“It’s a teaching tool for me because it has taught me umm, being a diabetic today uh, has given me an awareness of uh, myself, in our people, Anishnawbek umm, ahh, have tried to blend into European way of living. But, but there, but, but uh with the sugars and that salt, the potato chips and the pop and ice cream and all that stuff that we thought was good. Is good, mind you. But we, we overindulge in it.” (P 9)

There was a sense from this participant that what had been introduced was actually welcomed but as a result of overindulging in things that were new diabetes ensued. The notion of overindulgence was also noted in the following statement:

I think it’s a negative thing, I think, I don’t think a person should have diabetes you know, but again, I don’t know. It’s something that you can control, it’s something that goes wrong in your system, your pancreas. It just, probably I would think it’s a person that overindulges in things as I said from the beginning. I think when you overindulge in things in life, I think your pancreas is what suffers in you. (P 6)

This participant’s statement also included the idea that overindulgence occurs when one is not in control.

Often times the participants seemed to be quite vague about their culpability with respect to having contributed to developing diabetes (other than “overindulgence”?) . While this was often the case, some were able to suggest specific examples of what lifestyle choices they

believed to contribute to diabetes: *“I guess how I’m saying is smoking uh you know um does interfere with your uh, with your uh, the way your body operates, the way uh it cleanses itself and and uh smoking you know probably uh increases the chance of uh of uh of uh you know suffering from diabetes.”* (P 8)

While this last participant believed that smoking was a factor, the following participant provided yet another example which included a lack of exercise and the foods he had eaten: *“I started to realize that later on, lack of exercise because I couldn’t do to much. Because of my physical health. I uh, I will realized that possibly I will get diabetes and people just kinda said that to me as well. You don’t, you know because the way I ate.”* (P 9)

Some of the participants believed that diabetes had been inflicted upon them while others seemed to assume responsibility for this outcome. Regardless of the perception what seemed evident for the participants in this study was that diabetes was seen as an inevitable outcome that seemed to be more prevalent for Aboriginal peoples. What also seemed apparent was that most participants lived in fear of one day developing diabetes related complications.

For most of the participants it seemed inevitable that someday they would develop diabetes because it would either be passed down to them or occur as a result of lifestyle changes that for some seemed beyond their control. What was interesting to note was how some of the participants were able to make a direct link between these inevitabilities and the ways in which European contact had contributed to these outcomes.

In the preceding section the notion of inevitability with respect to diabetes for Aboriginal peoples was presented. Many reasons or explanations were provided by the participants to explain why diabetes was inevitable. The role of genetics as well as lifestyle choices was

suggested as possible explanations for the development of diabetes. In the following section I will now discuss the link that was made by the participants between their ways of eating and the development of diabetes. The connection made between diet and diabetes was conceptualized as *'linking changing ways of eating with illness'* and became the second property of developing diabetes.

5.2 *Linking changing ways of eating with illness*

Throughout the discussions about ways of acquiring and consuming foods in the past and the present a link was often made between the impact of changing ways of eating and the development of diabetes. It was not surprising to discover that the link between diabetes and eating seemed quite prominent throughout the interviews. The relationship between food and illness formed the second and final property of *developing diabetes* and was eventually conceptualized as linking changing ways to illness. There were two dimensions associated with the property of linking ways of eating with illness which included a contrast between Traditional ways and Western ways. With some exceptions as noted in the last chapter, the majority of the participants were either able to view traditional foods or ways of eating which were more commonly practiced in the past as likely being healthier. The notion of quality was introduced in chapter four in relation to traditional foods. Some of the participants appeared to view traditional foods or ways of eating as somehow being of lower quality. In retrospect it would appear that what they may have been suggesting is that traditional foods may not have been as healthy. Consequently the current dependence on Western foods was viewed as a less healthy and natural way of eating ultimately contributing to the development of diabetes which had not been

associated with Aboriginal peoples in any significant way until the middle of the twentieth century.

5.2.1 *Traditional ways*

As previously noted the participants' stories frequently took an interesting path in that there were often comparisons made between the past and the present. This was also the case when it came to linking the development of diabetes to ways of eating. Invariably their accounts began by explaining that back 'then' there seemed to be less diabetes and this appeared to be associated with what was considered to be more traditional ways of eating and living. Once again a link between living off the land and consuming 'traditional' foods or wild game was made with better health. There was often an association made between the medicinal properties of traditional foods or wild game. Interestingly even the participants who appeared most disconnected from their culture, land and ways of eating seemed to appreciate the more positive aspects of traditional ways. For one participant living off the land was something that she wished for and associated with better health: *"I wish I could just go live in a log cabin, I'd probably be happier and probably healthier you know, living off the land, pumping your own water. I said I should have been born like back in those days..."* (P15)

There seemed to be a suggestion that living off the land may have not only contributed to better health but possibly even preventing diabetes. In spite of this realization she as well as many of the other participants only seemed to be able to wish for a return to the old ways. Somehow this idealistic view no longer seemed realistic or even possible. It could perhaps even be argued that for some of the participants in this study may in fact not wish to return to the 'old ways'.

Unlike some of the participants who had come to reject traditional foods because they had grown to dislike the taste or because they associated it with being poor one participant was able to make a link between traditional food which he viewed as a form of medicine and health:

So when you eat muskrat it's like you're eating that medicine as well (...) It only eats health food. A moose only eats swamp food, roots and stuff like that (...) They eat balsam (...) They eat the bark of the poplar or the bark off of black diamond willow or bark off of uh, maple trees. Or they'll eat the spruce needles or eat cedar, what the rabbits eat (...) Now when you think about moose meat, deer meat, beaver meat, muskrat meat, rabbit meat, partridge, there all, that's health food... (P9)

This participant shared that he continued to incorporate wild game into his 'diet' whenever he could even if it was not always easy. The medicinal benefits of this way of eating were for him a healthier way of living. Although not explicitly stated he seemed to imply that consuming wild game could be viewed not only as being able to prevent diabetes but in the case where one already has the disease it could help them to stay healthy in spite of the illness.

The idea of being able to prevent diabetes from occurring through what was eaten and how it was prepared seemed possible for several of the participants. For example one participant suggested that it was possibly the lack of fat in wild game and the fact that foods were boiled that there may have been less diabetes in the past:

Well the wild meat doesn't have as much fat like the beef and the pork. The fat is (...) is what kept us ahh little bit on the slender side anyways now everybody's must be the fat in the (...) probably what do you call it (...) the way you cook? Cooking is the I could

say fried foods. It's in the beef (...) Just like we used to boil stuff. Now the only thing we boil is if you...make stew. (P2)

One participant also equated living off the land and the consumption of wild meat with being healthy and less diabetes: *"So like we were healthy there was no, when I look back at that time I was a child then and then umm, there wasn't hardly any diabetes around back then, you know and I look at the diet at that time and it was mostly because we were still living off of wild meat, you know."* (P9)

The link between living off the land, consuming certain foods such as wild game, and the method of preparation which were more prominent in the past was often attributed with better health and either the absence or at least a lower incidence of diabetes for Aboriginal peoples. What was interesting to note was that in spite of knowing that traditional ways of eating was viewed by most as a healthier way of living and associated with possibly preventing diabetes it was not commonly practiced. Instead many had adopted a less traditional diet for one that was more westernized and ultimately came at a cost.

5.2.2 *Western ways*

While some of the participants made a link between wild game and preventing diabetes others seem to make a connection between introduced foods that were often referred to as "white" and the development of diabetes. For example one participant appears to suggest that wheat and sugar containing foods were possibly linked to diabetes: *"I think that, well you know like ahh you watch TV and certainly mostly the natives that are getting the diabetes ...I don't know what's the cause ...what are we eating you know like is it wheat, breads?. ...you have to watch or limit how much sugar you take."* (P4)

Similarly another participant suggested that sugar and being overweight were related:
“You can prevent it, uh, my my like I said my mother tried to teach me, you’re going to be a diabetic and lose weight, don’t use sugar, don’t eat that type of thing.” (P5)

One participant provided a list of “white” foods that although taste good tend to be overindulged:

“Well from what the elders have said uh, it’s because of uh, things that are white. The flour, the salt, and the sugar because everything else was, was all natural... but uh with the sugars and that salt, the chips and the pop and ice cream and all that stuff that we thought was good... it is good, mind you but we, we overindulge in it, you know.” (P9)

Finally one participant suggested that in the past meals mostly consisted of wild game and meat but now included other “white” foods such as pastas:

Okay, you know what, from our okay when when we were young, your your um meals were mostly meat, your your you had fish, you had uh deer, you had moose, you had, and like there wasn’t a lot of other stuff, like you didn’t have that, so you’d have your bannock and you’d have your meat and after you started to eat like your macaroni and spaghetti and all all that other stuff, that’s when the diabetes came in, you know. That that’s how I see it anyway, you know, I’m pretty sure that’s how it happened because like you know all the extra like all the extra you know, your uh, what you’re eating, you know... (P19)

While “white foods” were associated with the development of diabetes for some, fast foods or junk foods were also considered to be linked to the development of diabetes by others.

For example one participant provided specific examples of fast food restaurants that had been introduced and might have unwittingly led to the development of diabetes for some:

Because of all the foods, McDonald's, uh, all the easy foods that have come into place. Like it is so much easier to go out and buy yourself something. A McDonald's meal or and Kentucky Fried Chicken and stuff like that. We never knew that stuff was gonna do that to us. Coz before you use to cook your meals. You'd have a meal and it was cooked; not today, you just run out to the grocery store and buy a frozen dinner or something. It wasn't that easy back then. (P7)

Once again the notion of ease of access seems to play a huge role in influencing food choices. This participant not unlike many others realized that the absence of certain types of foods in the past likely explained why diabetes was not as big of a problem.

One participant also made a link between fast food and the development of diabetes in his father: *"We never had diabetes in them days either, even my dad never had it. He never got his until later on too, when started eating all this junk (...) And the work, you had to work hard back then too (...) You had to carry water, split wood, your lifestyle."* (P16)

Similarly with another participant suggested that things that had been introduced and that she considered to be bad likely contributed to the development of diabetes. She also made a link between food and her father who died as a result of his diabetes:

"So just watching it throughout my life. Makes you, makes you think all this, all this bad stuff brought into us. We were healthy growing up at home and now all the, I don't know, all the different foods I guess. We were healthy growing up (...) My dad was diabetic too. He died of diabetes (...)." (P13)

The introduction of foods was not only labelled as ‘bad’ but directly linked to her father having died from diabetes. This participant appeared to suggest that it was the introduction of ‘bad’ foods that was ultimately responsible for this outcome.

Lastly another participant suggested that not having been taught the right way to eat and the consumption of fast food have likely contributed to the development of diabetes:

Well, I I it's a lack of um like they're not being motivated to work, like to uh exercise um and uh a lot of people who are diabetic are either on the chunky side you know they're always heavy-set people or um and if and I myself I see a lot of uh uh Native First Nation people eating a bag of chips, having some pop and I know it's not right, not right for them to be eating that but like who am I to say anything? Cause I did it myself. It's from uh I think it's from the lack of ...growing up and not being shown the right way to eat. (P20)

Once again a correlation between a disconnection from culture and the land and developing diabetes seemed to exist. Participants who had not been exposed to more traditional ways were more likely to share that their poor eating habits were responsible for their diabetes. They also seemed to be implying that perhaps if they had known differently they may not have developed the illness.

Two of the participants seemed to suggest that food additives, which are not typically found in wild game, are likely to blame or connected to the development of diabetes. For example one participant shared:

I know the traditional food has no uh stuff in it like uh I know, and the European food they put all kinds of stuff in it. That's probably why uh our sugar goes up when we eat

preservative food. And uh, Native food has no preservatives in them. Ya because uh I know there's um, I was watching that on TV and this one guy didn't have to take pills any more so he was just watching his diet with uh Native food. (P11)

And the other said : *"like the additives they put in food you know, cause they you see when we I lived on deer and you know moose and all that and all that and there's nothing really added until you know bought food stuff and then fast food you know, and all that and lack of exercise."* (P15)

A contrast between traditional foods as being natural and healthy with Western foods that contain additives was made by several of the participants. Participant # 11 shared a similar view to participant # 9 who earlier suggested that wild game was a form of medicine but also went on to suggest that it could also perhaps replace the need to have to take medication to treat one's diabetes.

While the composition of food seemed to be linked to diabetes for many, two of the participants seemed to imply that the unique make up of metabolism of Aboriginal people was somehow connected to the development of diabetes. For example one participant suggested that Aboriginal people were designed to live off the land and were not meant to live the way everyone else does:

Well um, I, I, I, the way I see it I think um, we're, we're a unique people, in um, in this world (...) we're different, uh we we have um, um, different metabolism (...) we we live our life differently as opposed to the mainstream society, um, we're more culturally uh oriented, uh um, I guess meaning like trying to live off Mother Earth and stuff like that (...) when you go to a grocery store, you know you buy this, you buy that and then

nobody reads the label on the, on on the, any of the products (...) we do hunt and fish you know. We, we uh, we depend on some of the uh what's provided for us so when when when uh, when you mix everything together you uh, you know, it doesn't balance out. (P5)

This theory seemed to be shared by one participant who also seemed to suggest that the metabolism of Aboriginal people was somehow unique: *"We took it to extreme and because of our, our, our metabolism make up or our body make up, body chemistry, ahh, its only been 400 or 500 years that we've been eating this, this way and all the commodity foods that were invented that we took upon ourselves."* (P9)

As a final point two of the participants implied that perhaps income was related to the development of diabetes. For example one participant suggested that as a result of having a limited income some Aboriginal people tended to consume more Western foods that were likely not as healthy while those with more financial means did not seem to be as affected:

(...) a lot of Native's like they're poor and they eat what they can afford and lots of it is fried scone (...) And it's all flour, so lots of eating all that stuff steady I think, helps diabetes along the way, rather than staying away from stuff like that (...) because I don't know very many rich Natives, not not then, now there's a few pretty well, they're well off, they're you know they're doing fine but and they don't have diabetes, so there's something with what with what we were eating but and then sweets and all that stuff. (P17)

This participant appears to be suggesting that Aboriginal peoples who have the financial means are somehow better able to make healthier choices when it comes to eating. There is no

suggestion that traditional foods or ways of eating are superior but rather that certain Western foods are certainly linked with diabetes.

For another participant a link was made between social assistance and the development of diabetes. The suggestion made was that with the introduction of welfare came diabetes while prior to that Aboriginal people lived off the land: *“I know Natives are really, the majority of them were diabetes but what I’ve been hearing is that long time ago we ate off the land and the government brought in welfare and all that, that’s why we’re all, all of a sudden diabetic and all that and sugar and salt and everything like that eh.” (P18)*

Once again a link is made between income, food selection and diabetes. In this case there is a suggestion that the creation of dependence through social assistance has led to decreasing reliance on the land and traditional foods and an increase in the reliance on Western foods which ultimately results in developing diabetes. This participant appears to be linking government or political influence on the development of diabetes. Although not explicitly stated there once again appears to be the suggestion that if Aboriginal peoples were more reliant on the land and traditional ways of eating and less so on Western ways there may be a lower incidence of diabetes.

Having the means to eat what is recommended as a person living with diabetes was a recurring theme for many of the participants. This is interesting to note since many of the participants seemed to realize or appreciate that living off the land or relying more on traditional foods was in some ways a more affordable way of living but at the same time cited various reasons for not doing so from not having the time, skills or energy to simply having outgrown this way of eating. This appears both as a dilemma and contradiction for those who appreciated

that traditional foods or ways of eating are likely to be better for you and more affordable. At the same time there seemed to be a feeling of being constrained by the high costs of Western foods that are commonly viewed as less healthy and in many cases seen as possibly contributing to the high rates of diabetes in Aboriginal peoples.

5.3 *Summary*

This chapter presented the second part of the findings from the data analysis of this research study. Data which consisted of transcript excerpts were used to explain and illustrate the two main properties associated with developing diabetes which included '*inevitable outcome*' and '*linking changing ways of eating with illness*'. The various dimensions for each of these properties were also presented and illustrated with data from the participant interviews which were used as a form of validation of the conceptualizations that were ultimately presented. The majority of the participants seemed to suggest that developing diabetes was inevitable either as a result of one's genetic make-up or as a result of their own doing. This would ultimately result in looming complications that most also viewed not only as inevitable but as frightening. A clear link was made between changing ways of eating and how this likely contributes to the onset of diabetes. In Chapter Six I will present the remaining findings related to the core category of '*choosing your medicine*' as represented by the participants in this study.

CHAPTER SIX

CHOOSING YOUR MEDICINE

In order to gain a better understanding of health beliefs and practices the participants were asked very broad questions such as what it meant for them to be healthy and what services they accessed. These discussions often prompted the need to further explore the nature and quality of the participant's health care experiences. The discourse surrounding health and diabetes related care once again took an interesting and often consistent path. The discussions were often broad and general at the outset but invariably most would begin to discuss their health in the context of living with diabetes. This findings chapter will present the third and final emergent category which was eventually named '*choosing your medicine*'. This category emerged during the participants' explanations of how and what health services they accessed either in general or as it related to their diabetes as well as their experiences in navigating or accessing health care services.

By delving further into the responses it soon became evident that some of the participants were often faced with having to make choices between conventional western medicine and traditional ways which most were able to justify. In some cases participants shared how ultimately they felt that when it came to diabetes care their options were limited or perhaps even chosen for them i.e. there only options seemed to be to access a medical clinic that was either in or outside of the community. For example one participant shared why he felt he had no other options of treatment when it came to his health or way of living: "*They had it taken away from us and my parents didn't show us none of it, didn't want to show us none of it...My dad was in residential and he didn't want to show us anything about Native ways.*" (P

11) For this participant the only health care he knew was Western medicine which was an outcome of the way he was raised, that is, not being acquainted with Indigenous traditions and practices which had essentially taken from him and his family. It would appear that he did not seem to have been left with any other options.

Many of the participants provided examples of what represented traditional medicine and healing practices while others appeared to focus mostly on Western type medicine. Regardless of their preferences it was evident that while some believed that Traditional and Western medicines and ways could be combined and complement one another, others felt that they should not be combined. For example this participant made it quite clear that it was one or the other: “*You can’t mix the two of them, either you’re gonna stick with one or the other.*” (P 16).

These three areas were eventually identified as the properties of the category ‘*choosing your medicine*’ and included: i) Traditional medicine; ii) Western medicine; and iii) combining Traditional and Western ways. The following sections will provide the reader with a detailed description of each of these three properties and their associated dimensions.

6.1 *Traditional Medicine*

The first property related to *choosing your medicine* was conceptualized as *Traditional medicine*. The topic of traditional medicine seemed to re-occur frequently and often without prompting. Most of the participants talked about what Traditional medicine or practices meant or represented for them by providing examples. There were various ways in which this topic was addressed and a number of terms used that seemed to have similar meanings. For example some participants used the term Traditional medicine while others might refer to Traditional ways or

practices. Some made reference to Indian medicine, Traditional healers or Medicine men or women. In the following example the participant shared examples of Traditional ways of healing as well as where the belief and experience came from:

And my grandmother for one had all kinds of medicines from Mother Earth, this was for this, that salve and a tonic for blood, and as a matter of fact my sister has the recipes to that and it cleansed, it cleansed the body and to me, when a medicine man comes along and says well you take this, I do believe, there's a reason why he's there. I do believe and he takes medicines from Mother Earth and I'll take that, and it was, and my grandmother taught us all that too. (P 3)

As noted in this last example women often seemed to play a more prominent role when it came to Traditional medicines and practices for many of the participants in this study.

What eventually emerged were three fairly consistent aspects related to the discourse surrounding Traditional medicine which included: i) examples or representations of traditional medicine, practices and healing; ii) the fact that this practice was often hidden or in some cases even forbidden; and iii) the perceived limits of traditional medicine in a general sense but most often in relation to diabetes care and management. These three perspectives formed the dimensions of the property *Traditional medicine* and included *what it is, hidden practice and limitations*. In the next section the three dimensions of the property *Traditional medicine* will be illustrated with data from the participant interviews.

6.1.1 *Meaning of traditional medicine*

The first dimension consisted of the numerous examples and ways in which the participants would talk about Traditional medicine or practices. For example two of the

participants shared: *“My mother she was traditional, she like, like she’s a healing person um like she did sweats and stuff like that.”* (P 14)

And *“(…) for me it’s like a cleansing… I used to go into sweats and that and you know and do that, ya if it makes you feel good, you know.”* (P 15)

For these participants a link was made between sweat lodges and healing or feeling good. The practice of sweat lodges and smudging was mentioned often over the course of the interviews. In the next example one of the participants shared how she had been exposed to being smudged by her mother with cedar while she and the rest of her family slept:

(…)’ my mother’s teachings and uh, she use to burn our medicines at night time. Some nights I’d wake up and I could smell, smell it and see her walking around with little, little tray there, smudging all of us, all her kids… In our home we had that. And picking, picking the cedar and we’d burn a lot of cedar, hang cedar on our doorways and um sage and that’s what I grew up…So I got the basic teachings at home. Just what my mom taught us. (P 13)

In another example one of the participants talked about a medicine that his father had used on him when he was younger: *“(…) my dad knew some little remedies not the whole thing like he would use like gum from a spruce tree and you know to draw out whatever’s in your skin there like infection…”* (P 4)

In this example the medicinal properties of spruce gum for treating infections was made by the participant. In another instance the following participant provided a number of examples without necessarily elaborating on the medicinal properties:

What is traditional medicine? Again I was telling you about the cedar tea umm, the rat root. Rat root is another form of tea. Umm, peppermint tea, Labrador tea, and balsam tea, you know are traditional teas...Muskrats eat muskrat root. So when you eat muskrat it's like you're eating that medicine as well. A moose only eats swamp food, roots and stuff like that. That's all he eats. A deer, the same thing. (P 9).

This participant went on however to elaborate how medicine could also be obtained through the consumption of wild game such as muskrat and deer. His representation of medicine seemed somewhat more complex in that it extended beyond the traditional notions of what medicines are which are often in the form of plants and herbs to include the example wild game.

For the following participant the example provided was not specific however she recalled how it had been used to treat colds:

My Mother like she was a real Native woman and she'd take every time she'd take us out into the go for walks and she'd show us the plants, that way you know she'd teach us um if we needed colds, she'd make us some you know I wouldn't even know this and this white plant she'd boil it up and she did all those um you know medicines. (P 15)

The notion of being a 'real Native woman' stood out in this participant's statement which seemed to suggest that the use of traditional medicines somehow implied authenticity.

In another example one of the participants shared how she had been exposed to medicine people in the past and provided an example of the symbolic nature of a tree as somehow representing health or perhaps even preventing illness:

There's a tree in front of my house here and it, and my dad says it's a black ash, he went way back and got it and I was so sick that time and of course my dad took me all

over the place, all the medicine men and everything. Well he said, you know what, we're gonna put that tree there... If that tree lives you'll live he says. Now look at the tree, it's way, it's big now and here I'm still here yet like, I'm meant to be here for some reason he said, you know. (P 19)

While many of the participants provided examples of traditional medicines or in some cases practices in a general sense some considered these occasionally as an alternative. For this participant cedar was a more suitable alternative to a flu vaccine which he believed had made his mother sick:

They brought out that uh, that flu vaccine. Okay. I never had one. I've never taken those flu vaccines and my mother; they talked my mother into going to take one. So she went. She took that flu shot and she got sick. She got terribly sick for about a week and a half. Almost 2 weeks I guess. And she cussed that she wasn't going to take that no more. And so every time they'd put that flyer out for, "[name] you going to come get your flu vaccine?" "Nope!" So I'd have to get her cedar and she would boil this up herself. She'll make herself a tea and that's what she drank for a couple of days. And she never went for that flu vaccine. She never got sick. (P 9)

Some believed that there are certain things that Western medicine cannot address. For example there was the belief that matters of a spiritual nature, in this case bad medicine which manifested in a physical way, could only be cured by traditional ways. In the following example a participant shared a story about 'bad medicine' and went on to account how Traditional medicine was the only thing that had worked:

And bad medicine was another thing I overheard them talking about like bear walker and stuff like that, bad medicine. Bad medicine, some of the medicines too is, my mother told me, "You'd find out how that person is that's doing that wrong to you." She had a sore on her foot that would not heal, right on the top of her, almost like a hole. You think the doctors could fix it? No. So she must have, one of my sister in laws took her down, I think it was West Bay, M'Chigeeng, down there to the medicine man. He cured her. He just took stuff out of her foot and she was okay after that. It was bad medicine. (P 13)

While the previous participant viewed Traditional medicine as being essential in some situations another participant suggested that she was returning to more traditional ways for healing because for her it addressed her spiritual, emotional, mental, and physical needs: "I'm getting back into a culture ways because I want to get healings and that and, ya. It's just uh spiritually, emotionally, mentally, physically." (P 11)

Although not explicitly stated she seemed to perhaps be implying that the care she had been receiving may not have been as 'holistic' as Traditional ways or as she put it "culture ways".

While some of the participants shared what appeared to be the more positive and beneficial aspects of Traditional medicines or practices others talked about some of the more negative aspects. For example the following participant shared how for some it was viewed as an evil practice that could harm one's mind: *"There's people that say no, you know, don't go there you know, those people are evil, don't see them people, they'll do things to your mind. You know, they'll do things you know, to you and that that's how some people uh look at it eh."* (P 5)

Although he did not specify who the ‘people’ were it was clear that he was referring to other Indigenous peoples. In yet another example the following participant shared that she did not use Traditional medicine because of her sister’s negative experience linking it to having been poisoned by something: *“My sister she practiced all this and that and sometimes I think she poisoned herself with all this Traditional stuff... I don’t remember like they say yeah long time ago they used to eat this, eat that for this and that you know what helps...lot of people died.”* (P 2)

It was clear that for this participant that there was a lot of doubt and perhaps even fear with respect to the use of Traditional medicines which she believed had been responsible for the death of many people in the past.

The concept of traditional medicine was almost always invariably linked to nature or the land. It also seemed that participants did not always appear to know or appreciate the exact purpose of some of the medicines or remedies used or how they even worked. In spite of this there seemed to be an acceptance at face value that the medicines had some sort of healing property that worked and this was rarely if ever questioned. What also seemed to emerge was the fact that many believed that traditional practices and knowledge seemed to be less accessible and possibly at risk of being lost:

You know my...my brother in law there he ahh he talks about Indian medicine he knows that they had awhile back, everything there’s a cure for everything it’s too bad that’s what I...that’s what I told him, it’s too bad like the medicine people didn’t you know didn’t educate somebody to keep...keep ahh on with it or one of their children to carry

on that medicine and it's lost...it's lost now because they didn't educate...but it's buried with them...it's too bad you know. (P 4)

Somehow it seemed either more convenient or less complicated to access Western medicine.

Similarly in this last example, the participant suggested that `traditional ways needed to be taught if they were to carry on since many of her people no longer seemed familiar with the practices: *“So language and our spiritual needs, our medicines, all of that. All of those cultural, spiritual, healing, medicines, language, and carry this on. Teach it; learn it to, as much as we couldn't to our people. Because a lot of our people don't, don't know any of it.”* (P 13)

Through the various examples of Traditional medicines and practices shared by the participants it was evident that they were often connected with nature or the land. What also seemed to recur was the fact that in many cases the use of Traditional medicines had been through a family member usually a parent or grandparent. There did not seem to be a sense that any of the participants themselves identified as healers or as administering the medicines themselves. Most of those interviewed who talked about Traditional medicine and practices seemed to be passive recipients.

In the preceding section a number of examples Traditional medicines and practices were provided. While most of the participants had some knowledge or familiarity with these it also became apparent that their use and access were often questioned. The idea that Traditional practices were at times hidden or not discussed became apparent.

6.1.2 *Hidden practice*

The second dimension of *Traditional medicines* was the idea that somehow this practice for some was hidden. This sense of hiding was evident not only in the sense of having to avoid being caught but also in the sense that many avoided discussing the use with their non-traditional health care providers for fear of being judged or perhaps even reprimanded. The notion of having to hide the practice was evident in the following statement: “*At that time you had to go to a medicine person during the night and don't let anybody now you're going.*” (P 13)

Similarly the following participant made reference to keeping the practice in the dark: “*When people at the time followed traditional, it was kept in the dark eh. The people ran a sweat lodge, it was kept at a distance where you had to go deep into the bushes so nobody will know about it because people did talk a lot. It's not as open as it is today.*” (P 6)

He went on to suggest that although that had been the practice for a long time that perhaps that was no longer the case. The idea that Traditional medicine and practices seemed to be making a comeback was also evident in his statement. This perception was also apparent in the following statement: “*It's [traditional medicine] trying to make a comeback you know through the medicine man...again you know we have to travel to go see the medicine man...we have to go through the states and I was careful and he gave us some medicine there to bring across the border and you know but before there was no border there was just going back and forth there if you want.*” (P 4)

There was a sense that even though it may be returning there was a still a sense that it was not acceptable and that it needed to be concealed in this case when crossing the border from the United States into Canada.

Being forbidden was also suggested as an explanation for either having to hide the use of Traditional medicines or stopping the practice altogether: *“The white man’s medicine forbids anyone there lot of things that were forbidden to the natives...I guess it was a no no to practise whatever if you knew medicine...it wasn’t allowed, a lot of things weren’t allowed like when we went to school we weren’t allowed to speak our language...”* (P 4) . This excerpt provides a good example of the outcome of forced assimilation when it comes to medicine and the resulting lack of control over one’s own traditional practices.

For the following participant the introduction of the `white man`s medicine is responsible for putting the practice on the back burner. *“They tended to shy away from like this back in the day...they were scared of trying new things...those were the days when medicine was starting to come in...white man’s medicine like the native medicine I guess was you know on the back burner.”* (P 4)

In spite of the fact that traditional practices were not as readily available as they perhaps had once been, those who did incorporate traditional ways or medicines often avoided sharing this information with a health care provider. This practice seemed to re-occur frequently as evidenced in the following statement:

I rarely um have uh any uh communication uh or you know discuss that with uh with a family doctor uh I’m pretty sure uh you know if I say you know uh a medicine man gives me a healer gives me this for this ailment and uh I’m pretty sure there’d be

questions eh, there'd be flags raised but uh I believe uh um they do respect that and uh and uh just like the way the uh the healer respects the western medication uh and uh but rarely um, probably not at all I discuss that with them, I keep that privately eh, ya. (P 5)

Although the participant believed on some level that his physician might have some respect for his traditional ways he could not be certain and as a result avoided bringing it up just in case. This perception was shared by several of the participants whenever the topic of Traditional medicine and practices came up. For example the following participant shared how he believed that 'they' being his healthcare providers didn't like it when it was used: "(...) even the Indian medicine they don't like you to take it either but you know what, sometimes Indian medicine helps you better than that you know." (P 19)

The idea of having to hide the practice of using traditional approaches seemed to present itself often. There was a sense that the practice had in a sense been pushed underground or hidden away over the years. Some believed that it was making a comeback. In spite of this many of the participants who believed in and used traditional modes of healing often felt the need to hide the practice from their non-traditional health care providers for various reasons.

In addition to the fact that often there was a need to hide the practice of traditional ways it was also quite clear that many participants believed that Traditional medicines and practices ultimately had their limitations.

6.1.3 *Limitations of Traditional medicine*

As demonstrated in a previous section many of the participants were able to provide examples of what Traditional medicine or practices represented for them. Most of their examples were in reference to general health or conditions often other than diabetes. It was apparent that,

for the most part, those who had experience with Traditional medicines either past or present seemed unaware of any treatments specific for treating diabetes. *“I never took any medicine from any traditional medicine in regards to diabetes because I really don’t know if, if there is something that would bring the sugar down. But if there was I would most definitely take it.”* (P 7)

This was a commonly shared perspective. It seemed that many of the participants were often unaware of the existence of any traditional methods of treating diabetes. That being said several implied that if there were they would certainly be open to the idea.

“But I do believe in the traditional medicine a lot and the naturalness of it and uh, I wish I knew more about it or whatever because I think that if there were some way of healing traditionally from uh, for the diabetes itself and making a balance there. I’m not aware of any. I would definitely go that route because I mean uh, (ahem) I mean having respect for the medicine itself and walking in balance is the key”. (P 12)

Some participants however seemed to have heard of traditional remedies for treating diabetes however they often seemed unaware of any specific details as noted in the following excerpt: *“I started thinking about uh medicine people. I says well I’m a, I don’t know how you’d say it, our uh elder friend that always use to come over. Like, she use to tell, she use to drink something and she had diabetes. Once she started drinking that stuff, it went away but I never really asked her eh.”* (P 8)

In this last example although he had heard of Traditional medicines that could possibly treat diabetes he was not aware of what it was. This finding may simply be a reflection of this

particular sample. This was a commonly shared perspective amongst the participants of this study.

Only one of the participants seemed to be aware of the possible medicinal properties of blueberries in helping to control blood sugars as noted in the following excerpt:

Well you know what eh? The only thing I took was the was the blueberry, the blueberry root my brother made me, and that kinda brought it down eh where it's livable and it's not, it's not way up in the 15 and 16s you know, it's right down to 7 and, so like I I drank it and I don't like you know, I'm not gonna drink it forever, it I drank it and got it down and there, that's the blueberry root. It helps to bring down your sugar. (P 19)

In this last example it appeared that although her sugar had improved while drinking a blueberry root drink it wasn't something that she planned to do indefinitely.

Another aspect of the perceived limitations of Traditional medicine was in relation to its access or availability: *"you know you had to go far and wide to find a healer, if you didn't have one here in [community] you practically had to go out to uh, maybe West Bay or Sault Ste. Marie, that's how far and wide that you had to go to find them. And there were few."* (P 6)

For this last participant and many others the question of access to Traditional medicines, healers or practices was often a limiting factor. There was a sense that if it were more readily available that they would likely access it more frequently.

The lack of familiarity with Traditional medicines as well as the idea that access was an issue was also present in the following example:

I go to my family doctor of the white society way I'll call it and all that. I find it's more beneficial for me, cause if I go to the traditional ways sometimes you gotta be

sent out to the bush to look for your own, of medicines (clears throat) and all that, if they don't (clears throat) supply what you need whereas to the drugstore I go over there and it's right there. (P 6)

In this last example the idea that it was somehow more convenient to access a drugstore than to have to find your medicines in the bush was noted. This perspective seemed to suggest yet another perceived limitation when it came to Traditional medicines or practices. This notion of convenience was also addressed earlier in Chapter four in relation to accessing foods from a grocery store versus having to hunt or fish for your food.

For others the limitations of Traditional medicines extended to situations in which advanced health care services such as dialysis had become required. For example one of the participants shared the following:

I was looking back on my mother and then my grandmother and that's how they ended up on dialysis and that was every second day so and like my mother she was trying the traditional way like with all her teaching and everything and she couldn't do that any more, she couldn't go travelling or and then cause I noticed when I was going in the sweats my sugar would spike way up into the 20s so I kinda had to shy away from that and so I had to put on hold or not hold but ya but then everybody says well go back in there cause you're supposed to you know, try to get healed and say well it's not working for me, it's going the opposite so. (P 14)

Another participant shared how she had considered Traditional medicine to help treat her infertility but eventually had to see a 'white doctor' in order to be able to conceive:

I went to medicine men eh, I had a hard time conceiving when my husband first met, I just wanted a baby so badly, it was just like an inner you know I, but there was something wrong with me but I went to medicine men and after medicine man, finally this one medicine man said it has to be by the white doctors so I had to go and they did an operation on me that you know I guess the medicine man couldn't do, then shortly after that I got pregnant. (P 15)

For some of the participants their uncertainty or at times fear with regards to the effectiveness of Traditional medicines seemed to impose limits:

Uh tradition as far as I know tradition, blueberries, cedar boughs, like you boil water and drink cedar tea, stuff like that but to do is different. I've been asked about it but why don't you get some blueberries? Okay blueberries I don't mind eating them but like cedar boughs and boiling it up and make cedar tea...Like I'm kinda of okay it's the Indian way, Indian medicine way, it works on some people apparently I don't I don't know for sure... (P 18)

And: *"I've been to medicine people and never really helped eh, I don't think, I don't know, you know because we weren't brought up that way." (P 17)*

Not having been raised in the traditional way seemed to lead some to question the effectiveness of these approaches.

The topic of Traditional medicine, healers and practices was often addressed by the participants. A number of examples were shared from past and in some cases recent experiences. While some viewed this way as positive some provided examples of having had a negative experience while accessing 'Traditional medicine' either for themselves or for another person.

These experiences along with fear of what non-Indigenous health care providers might think led some of the participants to a fear of disclosing traditional practices and keeping it hidden or in some cases even avoiding the practice altogether.

Finally while a number of examples were shared regarding the medicinal properties of various medicines a number of participants believed that traditional ways and medicines had their limitations and that they likely could not be relied upon exclusively whether in relation to health and illness in general or when it came to treating their diabetes.

The western side there they studied it. They probably know more about it cause I don't think a west I mean a traditional person could give you a tonsillectomy or something like that...Well traditional healer's they learn from somebody else usually their parents had practiced it before probably passed from way down through the generations. (P 2)

The previous participant used a very specific example with which to illustrate a limitation of Traditional medicine with her reference to requiring a surgical procedure which could only be provided by the 'western side'. The other striking aspect of her statement was her suggestion that Western medicine was somehow superior because it had been studied versus having simply been handed down through the generations. The limitations in this case were attributed using a very Western and positivist view of what was considered legitimate knowledge or practice by many of the other participants. On the other hand what is perhaps being suggested is that as a result of traditional knowledge no longer being passed down as it once was contemporary traditional practitioners may not possess sufficient historical

knowledge to be practicing. Then again perhaps this participant was simply questioning the legitimacy of the modern traditionalists, knowledge.

There was the suggestion that the idea that invasive procedures or surgery are not in the scope of practice of Traditional healers but specific to Western medicine or physicians. It seemed that Western medicine had more to offer. This notion of the limitations of traditional medicines is quite evident and a recurring theme: *“Like, you, it’s all right to see a traditional doctor as long as you know when to see, like your family doctor. Like there’s certain times you do have to go under the knife or take certain medications that your traditional healer can’t take, give you.”* (P 6)

There was also a perception by some that the role of Western medicine existed to address one’s physical needs and Traditional medicine was perhaps limited to addressing the spiritual aspects of one’s health:

“If I get sick taking medication keeps my function in my body under control and as far as uh traditional healer, the number one reason um uh I guess to me why I would see a medicine man is uh for guidance.” (P 15)

What became apparent was that for some of the participants Western or ‘white man’s’ medicine seemed to play a more significant role when it came to their physical health care needs. As a result of either the perceived limitations or fear of Traditional medicines many of the participants had come to rely on Western medicine either in part or in some cases entirely. In the following section I will now address the second property of ‘*choosing your medicine*’ which has been conceptualized as Western medicine.

6.2 Western Medicine

The second property related to *choosing your medicine* was conceptualized as *Western medicine*. Although this term was not consistently used by the participants, it became apparent that when they were referring to non-traditional forms of health care what they were in fact talking about was Western medicine. Similarly to the topic of Traditional medicines the participants occasionally used different terms such as European, white man's or even mainstream medicine when referring to Western medicine. "*Those were the days when medicine was starting to come in...white man's medicine.*" P 4)

Throughout the discourse on Western medicine the participants often provided the reasons why they had elected to access this form of health care instead of Traditional medicines or ways. Their reasons ranged from not having been exposed which caused many not to believe in Traditional medicines to no longer having access because Traditional healing practices and knowledge had been lost as noted in a preceding section. This lack of exposure ultimately led many to 'stick' with Western medicine which had become familiar.

What eventually emerged were two aspects related to the discourse surrounding Western medicine which included: i) explanations for having adopted Western medicine; and ii) electing to conform to Western medicine. These two perspectives formed the dimensions of the property *Western medicine* and included *how it came to be, and doing what you are told*. In the next section the two dimensions of the property *Western medicine* will be illustrated with data from the participant interviews.

6.2.1 *How it came to be*

In Chapter Four several of the participants shared that the reason that they did not follow a more traditional diet or way of eating was because they had not been raised that way or exposed to that way of living. This also seemed to be the case when it came to explaining why some had come to rely on Western medicine either in part or completely. For a number of the participants, their reason for preferring or accessing Western medicine was simply because they had no previous experiences or knowledge about some of the traditional ways. The lack of exposure seemed to explain why several of the participants were unfamiliar with traditional ways and was evident in the following three examples: *“I rely more on the Western medicine because it’s what I know I guess in the way I was raised and assimilated into that.”* (P 12)

In this last example the participant even used the word assimilated to explain why she had come to rely on Western medicine. Although the next two examples did not mention health directly they did seem to further support the idea that not having been exposed to various cultural or traditional practices resulted in not being familiar: *“I didn’t know anything about sweat lodges you know because that wasn’t introduced to us.”* (P 3)

And: *“We weren’t taught any of the culture and I grew up here on the reserve.”* (P 12)

For the following participant not only did she lack experience with traditional ways but even the thought of considering it appeared challenging for her: *“Well it’s hard for me to go the other way because I was never taught that way so I don’t know the difference...I don’t know anything about the teachings.”* (P 11)

In the preceding examples the participants did not qualify why they had not been exposed to traditional ways growing up whereas in the next case the participant shared that attending

residential school when she was younger prevented her from being exposed to Traditional medicine:

Residential school came in. You know, I find once you were removed from your home, where security was and you were put into a world that you did not understand, I think you lost a lot of stuff in between. Like and that's where the teachings of everything went lost for the Anishnabek people and when they did come back, well, they, they did not understand the Anishnabe way no more, or they didn't want to cause they were, if you practiced your traditional way once you got into that residential school while you were punished for it. And by the time that everything shut down, well you didn't care no more because all the length of time that you were in residential school, you knew you were going to be punished for that so in that process you just let go of everything and, and some people, Anishnabek people never came back to it. (P 6)

Not only had she been removed from her ways of living but she learned that while away in residential school if she 'practiced' her traditional ways she would get punished. This negative reinforcement of sorts contributed to a great extent in her perhaps turning away from even considering Traditional medicines or practices in favour of adopting Western ways. This outcome was not exclusive to this participant and seemed to apply to most that had either attended residential school personally or had a parent who had attended.

In another example one of the participants shared that her physician suggested that she was the only one who should be providing care. Western medicine or ways was somehow being imposed: *"Well" she said, "I think you have too many people working in your health and I'm supposed to be the one monitoring it and you have too many people in there."*(P 12)

The context of this response was during an exchange about being treated for diabetes by her physician but also choosing to access diabetes services in her community. The message she was given by her physician was that clearly the physician should be in charge of her care and that there should not be so many people involved. This seemed to be minimizing other services and suggesting that the physician's care was somehow superior to traditional ways.

Another reason that seemed to contribute to a turning away of sorts from Traditional medicine was attributed to the loss of elders who had once played an important role and seemed to be the keepers of traditional practices and knowledge:

They'd come in and sit there and talk while you were sick. Just to make sure, you know, they would keep you company and all that. But all that stopped even. There is nothing like that anymore. Once we lost our elders and but that's uh, and then the doctors started coming. We had doctors coming in here too. My grandmother, I remember the doctor coming to see my grandmother. (P 7)

What was particularly striking about this excerpt was the idea that once the elders were lost and 'physicians' started to come into the community this and possibly many other similar traditional practices likely ceased to exist. What was once a common way of dealing with illness was no longer being practiced and likely helped to explain why some of the participants had come to depend or perhaps rely more on Western medicine.

Similarly the following participant seemed to support the idea of a loss of traditional knowledge which likely contributed to a loss of traditional practices: *"You know Indian medicine it's lost now because they didn't educate...but it's buried with them...it's too bad you know."* (P 4)

For some there seemed to be a connection between the loss of traditional practices and the subsequent adoption of Western medicine. A connection was also made between the loss of elders or keepers of this knowledge and the questioning the legitimacy of contemporary traditional ways or practices:

At that time it was very sacred, that only a few people, a handful of people knew how to run a sweat lodge, a few people, there were hardly any healers. Now today every backyard you look in, you almost had a, has a lodge and everybody, every third person you come across is a pipe carrier or a traditional healer or all that. Everybody's claiming too much, when it, it wasn't really something that, that was given to you at the time of, my father often said, if you're going to become a healer, a carrier of the pipe, you know that, your family knew that from the time you started to walk because, I don't know, it was different, there was, there was ways they knew I guess. But now, everybody wants to be a healer, everybody wants to be a lodge keeper eh? Everybody's just growing for that and to be truly honest with you, this is what I know, there's money involved in it. So I think everybody's in for the money for it eh, that's what's going on there. (P 6)

There was a perception by this participant that perhaps Traditional medicine and healers were no longer authentic or perhaps even effective. The suggestion being made by this participant that traditional healers appear to be in overabundance is interesting. There is evidence in this statement that traditional medicine is somehow changing and that for some the changes are being critiqued. The basis for the critique is not always readily apparent. Consequently for her and others who held similar beliefs the only options remaining might be Western medicine.

Another reason that seemed to explain a reliance on Western medicine seemed to be attributed to the idea of sticking with the familiar: *“I stick to the one, like the doctor I see...he’s always been the one I saw and he knows all my records...he’s a good doctor whenever he sees me...he stays on top of my diabetes...he’s a good doctor.”* (P 4)

There were a number of reasons that seemed to explain why Western medicine had become the main source of health care for many of the participants. A lack of exposure to Traditional medicines and practices growing up was most often the reason. The loss of elders who often were the keepers of traditional knowledge was also suggested as a possible reason. Finally for some it was simply a matter of sticking with the familiar.

In the following section I will address the second dimension of Western medicine which was eventually conceptualized as *doing what you are told*.

6.2.2 *Doing what you are told*

In the preceding section a number of examples and explanations were provided to explain why many of the participants in this study had come to rely primarily on Western medicine. It would appear that for the most part this outcome was often not necessarily a matter of choice but rather one that had become imposed or perhaps resulted through a lack awareness or availability of any other options. In addition it also became increasingly obvious that having to access Western medicine often meant having to do what you or told or at the very least feeling the need to somehow conform. What was interesting to note was that for many of the participants being told what to do did not seem to be an issue and in many instances even seemed quite acceptable and justifiable. *“you wanna live healthy you gotta do what you’re you’re told, you gotta listen. You go, you go see a doctor, she knows what I’m*

supposed to have.” (P 16) For this participant there was no question that if she wanted to remain healthy she had to ‘do what she was told’.

Similarly in the next example the participant shared how he ‘followed’ what he was told by a dietician and his physician: *“I followed the dietician what she told me in the beginning, you know or I follow what my doctor said. I follow what the books say or what the workshops have said. I follow that.” (P 9).*

There was no sense that doing what he was told was problematic for him.

At times the concept of doing what one is told was presented in the context of behaving. The notion of behaving was ever present in this next example: *“I have that internist, he’s good, I like him but I only see him every six months and the renal guy, he’s okay too and the heart guy he’s alright, there’s one more, I forget. But they all seem, I get along good with them and I listen when they tell me, you know, this is how you do it and whatever. Follow the rules and I’m behaving.” (P 17)*

For this last participant following the rules and behaving represented examples of how he was doing what he was told to do by his specialists. Once again there is no sense of questioning or challenging but rather a simple acceptance of the rules.

Similarly in the next excerpt there is a suggestion that one is required to behave and do what they are told or they might suffer the consequences:

Behave (laughs). Like you know, try, if the doctor’s trying to help you do this and you do that and you can and whatever, follow those, he’s trying to help you and if you don’t want to drop dead some place of a massive heart attack or under like sugars are under

or way too high, if you don't listen you're gonna pay for it in the end, it might take a while but in the end you'll pay. (P 14)

While some of the participants did not seem to have a problem with doing what they were told others did and were able to provide an explanation as to why they had adopted this position in the context of the relationship with their health care provider. For example the following excerpt clearly demonstrated that the decision to conform was often associated to an underlying fear that had been instilled in many while attending residential school:

(...) then the colonization, like the intergenerational, all this stuff is affect, we're affected by that. But nobody believes that, nobody understands that. The intergenerational effects because I know myself, I, I live with a lot of umm, that fear, eh, I live with fear and but since I've done a lot of work on myself, healing myself. I went to residential school too. A lot of the behaviours you live with that but as we, as I'm going along I have to remember that those behaviours still affect me. So um, like I was talking about with the doctors. I have that fear of, uh, authority, like they're gonna tell you what to do, always telling you how to behave you know. You couldn't behave like yourself because colonization is like the government sends you to residential schools to be like them. (P 7)

Similarly in the following excerpt the participant clearly demonstrated that she was doing what she was told out of fear of angering her physician: *"My doctor, she say take this and that's it and if you mix anything else you're, your problem, not mine. I've been scared she'd get mad. She wouldn't like it if I was mixing my medicines."* (P 6). This excerpt appears to be a good

example of being treated like a child. This would certainly represent a classic example of paternalistic behaviour within the context of a health care interaction.

The notion of not appreciating that somehow as a patient one could have a say in their care and that ultimately all the decisions rested with the physician was also quite noticeable in this next example: *“I have a sister that puts away her Metformin because she thinks she doesn’t need it or she’ll knock herself down a pill herself eh. You can’t do that. You gotta let your doctor do that...Doctor puts you on that, it’s not up to you to take yourself off them.”* (P 13)

The idea of not questioning or even challenging the physician’s authority was often present and seemed to provide an explanation of why doing what one is told was required.

Although many of the participants did not appear to have a problem with being told what to do when I came to their health or diabetes care others felt a sense of being controlled: *“(...) it makes you angry...they want to control you...you got to do this you got to do that you know...”*(P 4) For this participant being told what to do by his health care provider made him feel angry. There was no sense that his feelings had ever or would ever be shared with his health care provider.

The notion of doing what you are told was recurring but usually in the context of Western medicine. There was a sense that this often went unquestioned by some and questioned yet unchallenged by others. Interestingly this paternalistic and superior approach was never evident when participants talked about accessing traditional medicine or during their encounters with traditional healers. The notions of paternalism, domination, and uneven power relations often seemed present in the context of accessing Western medicine.

In the following section I will now address the third property of '*combining your medicine*' which has been conceptualized as combining Traditional and Western ways.

6.3 *Combining Traditional and Western ways*

The third property related to *choosing your medicine* was conceptualized as *combining Traditional and Western ways*. Throughout the discourse surrounding health care practices and beliefs it soon became apparent that there were two schools of thinking on the issue. Some of the participants believed that Traditional and Western medicines could be combined in a complimentary manner: "*When we were young kids my dad taught us you have to respect both ways.*" (P 3)

Others believed that they should not. "*I heard is that they don't work together, you gotta take one or the other.*" (P 16) The participants provided reasons and justifications for why some believed that these two perspectives were either complimentary or not. These two perspectives formed the dimensions of the property *Combining Traditional and Western ways* and included *complimentary, and it's one or the other*. In the next section these two dimensions will be illustrated with data from the participant interviews.

6.3.1 *Complementary*

In the preceding sections a number of examples and explanations were provided to explain perspectives on both Traditional medicine and Western medicine. It seemed apparent that none of the participants who were interviewed for this study had come to rely exclusively on Traditional medicines. What did seem to surface was that many believed that these two approaches could be combined.

In the following two examples the first demonstrated that combining Traditional and Western ways was deemed acceptable because the participant's father said they could: *"My dad says they work together."* (P 19)

While in the second example the participant confirmed the belief as a result of his own practice: *"Like I'm using western medicine but I'm also using traditional medicine."* (P 9)

In the next example the participant appears to be suggesting that at times Western medicine was required in addition to Traditional ways: *"I remember well my mother did practice a little bit and she was with the western doctor to when she needed."* (P 2)

In the following example the participant seemed to appreciate the complimentary nature of the two approaches. He viewed Traditional medicine or healers as dealing with or staying healthy while Western medicine could address sickness or the body: *"There's a balance eh, um the physical part of my being uh I need medication for it in order to function uh and in order to function uh as a as a as a person I want to be I was taught uh you know uh I have to see a I see a healer at least four times a year."* (P 5) In this last example there is a suggestion that each approach may have its own limitations but in combination can contribute to establishing balance.

In keeping with the notion of doing what one is told, one of the participants provided the following example in which she sought the approval to combine the two from her family physician:

I had one, like they tell me, well make sure you follow-up with your doctor on that eh... I had seen my family doctor after seeing a traditional doctor, one time I told him what the traditional doctor told me...I begin by asking him how he feels about Anishnawbek people, his clients, patients seeing a traditional healer. And he says I've got no problem

with that, as he said as long as you know when to see a doctor. If, if uh, your healer can't heal, then find somebody that will help you with it. That's what he told me. (P 6)

Even though she seemed to believe in the practice of combining the ways there still seemed to be the need to obtain permission before proceeding.

The notion of one complimenting the other was also present in the following two statements:

But anyway that's what I'm saying about, about our medicine versus, like even uh my diabetic medicine. I have uh, there's medicine for that as well, you know. And one of my Elders out West said give me some and I drank it. Even my friend from Cape Breton, Cape Breton Island, she gave him some as well and he didn't get the uh, the what kinds of medicines in there, he didn't get that so it only last him, a gallon only last you so long. But his sugar was stable because he was on the needles too eh, big time. (P 9)

And: *"I heard this one girl, she was taking that taking that, didn't take her pills and she died so I'm kinda afraid of that. She was a healthy girl and she tried the traditional way and I guess I don't know sometimes they say it works, if you take your Western medicine and the traditional medicine but take it both same time. Don't quit using either one."* (P 11)

Many of the participants seemed to suggest that combining Traditional and Western medicines was an acceptable practice. None of the accounts seemed to provide any particular justification or explanations as to why they held the beliefs other than having been told it was the case or as result of their own personal experiences in combining the two. It seemed that what the participants were implying was that in a perfect world there is no reason why the two ways could

not be combined. Although this was a commonly shared belief, others suggested that in fact Traditional and Western ways either could not or should not be combined.

6.3.2 *They don't mix*

In the preceding section a number of examples were provided through participant excerpts demonstrating that many participants believed that Traditional and Western ways could be combined. Although this perception was shared by many, others felt that they should not be combined by providing various justifications or explanations.

For some of the participants there was a belief that the two approaches could not be combined because those who went the 'traditional way' believed this to be true: *"people that had gone to the traditional way walked away from the church completely, they don't go there at all because they say the two don't mix, you can't have the two going for you."* (P 6)

Conversely others believed that having chosen to become a Christian was the reason. For the following participant a determining factor was his faith. As a result of being a Christian it was his belief that he should not be combining Traditional and Western ways: *"I got to be Christian later on in 80. You can't mix the two of them [traditional and Christianity] either, either you're gonna stick with one or the other."* (P 16)

Another reason that seemed to emerge possibly explaining why there was a perception that Traditional and Western ways should not be combined was the fear of not knowing what might happen if you combined the two: *"I don't really know the diabetes medicines all that well ...I get scared to mix it with the traditional medicines."* (P 7)

In another example the following participant was not necessarily advocating for one over the other but she did seem to imply that Traditional medicine, at least in her opinion, had less

side effects compared to Western medicine possibly suggesting that she favored one over the other: “Sometimes I think uh the Western has uh side effects to their medicine and when I take a traditional medicine I don’t have no side effects.” (P 11)

The fear of the unknown or of developing an interaction or side effects when combining the two ways also seemed to reoccur often. For example:

I heard is that they don’t work together, you gotta take one or the other. Ya, that some, some of the traditional people say now, well, we’re gonna try to work together and I don’t know, never heard of it working out. It’s probably from the side effects they have, I’m not sure what it was, what it is. Cause uh there’s a lot in the Western that’s either used for something else. (P 11)

The following participant provided a specific fact of experiencing a reaction after participating in a sweat lodge ceremony:

I had an experience uh, oh a long time ago ...So uh, we go into the, like she was medicine woman eh... like next thing you know I’m in here for about 5 minutes I guess and then all of a sudden my knees just started burning. What’s up? So I gotta wait, you gotta wait. Like I’m just screaming eh. How hot my knees are eh, and I’m trying to dig them into the sand to cool them off. Nothing was helping. So we go out. “Maybe you should go into the sweat again and see what’s gonna happen.”...that was when I was just starting to get diabetes eh I was thinking. Well, I wonder if those pills I’m taking eh, could be affecting me, like maybe when I went into the sweat maybe there was something. Uh, maybe there was something, uh, maybe. I don’t know like there was a reaction. I was thinking eh. So I, I wasn’t sure eh. I think you have to believe in it and

that's the part, I don't believe eh, that's what I'm thinking....that's what I started thinking eh maybe you have to really believe so I don't know. (P 8)

Although he had no concrete proof that combining a Traditional and Western way together resulted in his reaction he suggested that it was possibly his lack of faith in the sweat that ultimately led to the reaction that he experienced. In other words he appears to be suggesting that one has to believe in traditional medicine for it to work.

6.4 *Summary*

In the preceding section the beliefs and practices with respect to combining Traditional and Western medicines or practices were addressed. The two dimensions included the belief by some that the two approaches were complementary while the second seemed to suggest that they should not be combined. Through the presentation of various transcription excerpts a number of examples were provided in order to justify why one perspective was maintained over the other. Most of the justifications provided either for or against the combining of Traditional or Western ways were based on beliefs and rarely included any concrete or specific explanations. Many of the participants had reached their conclusions usually as a result of a personal or witnessed experience.

This chapter presented the findings related to the third and final category of *choosing your medicine*. In the next and final chapter of this thesis I will present the substantive grounded theory that ultimately emerged as well as provide an interpretation of the results of this study and the integration of the findings with the literature.

CHAPTER SEVEN:

DISCUSSION

The preceding chapters, which have reported on the findings from this constructivist grounded theory study on Aboriginal peoples' experiences with living with type II diabetes, have clearly demonstrated the presence of historical and ongoing colonial impacts on the experience and perceptions about the development of diabetes and how this impact influences subsequent health care choices. The key findings interacted in such a manner as to suggest that many of the participants seemed to at times feel powerless when it comes to the ways in which their diets have changed over time, developing diabetes and when it comes to health care options whether it be for diabetes or general health.

As evidenced on a number of occasions most of the participants' discourse appeared to demonstrate an ensuing need to adapt to their ever changing circumstances which most felt to be out of their control and even at times imposed. The historic and ongoing impacts of colonization were quite present in the diabetes experience of the majority of the participants.

7.1 *The impact of colonization on type II diabetes: presenting the substantive theory*

I was able to advance my substantive theory by adhering to a grounded theory methodology in analyzing the data that was collected. Throughout the analytical process concepts were identified which were subsequently grouped together under increasingly higher order subcategories and eventually categories (Charmaz, 2006). The three main categories that emerged were *changing ways of eating, developing diabetes, and choosing your medicine*. It was through the application of this process that I was able to provide a foundation for the

development of the substantive theory that emerged from the experiences of the Aboriginal peoples living with type II diabetes who participated in this study.

As a result of my analysis of the interaction between the key findings of this study I have developed a substantive theory that suggests that Aboriginal peoples who participated in this study and who live with type II diabetes often viewed the development of diabetes as an inevitable biomedical or cultural outcome. Many lived with the perception that there was ‘no going back’ to the way things once were prior to contact and that as a result they have had to adapt to new ways which can at times be at odds with Aboriginal world views. This perception may in part be influenced by the idea that, for some of the participants in this study, Aboriginal culture is something of the past and may no longer exist. The idea of culture as something that is evolving and changing did not appear to exist for some of the participants. Perhaps there is a perception that Aboriginal culture has been lost as a result of colonization and no longer exists.

It also seemed a matter for some of not having a choice and having to learn to live in the ‘white’ world. There was evidence that the principles of cultural safety were often lacking especially within the contexts of interacting with the health care system. For some of the participants this adaptation meant accepting and incorporating Western ways while for others it meant being able to embrace the best of both worlds when it comes to living with type II diabetes. The latter perspective may represent an example of the presence of self-determination with respect to type II diabetes care. This method of adapting, which appears to be embracing a complementary approach to diabetes care, could be seen as an example of decolonized diabetes care.

This adaptation appears to further suggest that a complementary approach that considers both Traditional and Western ways might provide a framework for a decolonized model of type II diabetes care for Aboriginal peoples. This approach is neither exclusively Traditional nor Western but rather complementary and decolonizing in the sense that individuals can appreciate the benefit of combining the two but perhaps more importantly are given a choice and empowered by being able to determine how they want to live with and receive care for their diabetes. This model also consists of the realization that type II diabetes goes beyond the biomedical perspective and considers the impact that colonization has had on the disruption of many of the ways of living of Aboriginal peoples since European contact (Ferreira and Lang, 2006; Joe and Young, 1998). This substantive theory is dynamic in nature and serves to represent the experience of Aboriginal peoples living with type II diabetes from the North Shore area of Lake Huron. It further helps to explain and justify a variety of participant experiences.

This final chapter will now provide an interpretation of the key findings of this study and the integration of these findings with the literature. In the last three chapters I have presented the findings from my analysis of the interviews with a group of twenty two Aboriginal peoples living with type II diabetes and who reside along the North Shore of Lake Huron in North Eastern Ontario. The aim of this research was to identify and contextualize issues faced by Aboriginal peoples who live with type II diabetes and to develop a substantive grounded theory that might explain their experiences which in turn could assist in the development of a decolonized model of diabetes care for this population. My goal was to explore this phenomenon further by interviewing Aboriginal people living with type II

diabetes. In the following discussion I will demonstrate how I am promoting and advancing the discourse from one of colonization to that of decolonization.

The main research question being asked was:

What is the impact of colonization on the lived experience and perceptions about developing type II diabetes for Aboriginal peoples living along the North Shore of Lake Huron?

In addressing the original research question it became evident that colonization has had an impact on the diabetes experience for many of the participants in this study. Furthermore it also became evident that a need for exploring a more decolonized approach to type II diabetes care in this particular population at least might be beneficial.

7.2 Colonization's impact on health and eating

It has been well documented in the literature that over the years the way Aboriginal peoples eat has changed, there is no question (Earle, 2011; Emberley, 2009; Frideres & Gadacz, 2008; Turner and Turner, 2008; Ferreira and Lang, 2006; Waldram et al., 2006; Kelm, 1998; Kuhnlein, 1992). This was certainly the case for the participants in this study. European contact and the introduction of diseases previously unknown to Aboriginal peoples impacted food sources and resources (Wazayatawin, 2005; Kelm, 1998). Environmental changes have also played a role in impacting traditional food sources (Early, 2011; Guyot, Dickson, Paci, Furgal, & Chan, 2006; Garro, 1995).

A unique finding from this study was the link that was made by some of the participants between historic changes in ways of eating and the development of higher rates of diabetes. More specifically several of the participants had been able to go beyond the commonly held

perception that diabetes was a predominantly biological condition to consider how a drastic change in diet from one that was more reliant on the land to one that had become primarily dependent on Western market foods. Similar yet perhaps less in depth conclusions were reached by Manitowabi and Maar (2013) in their paper exploring Aboriginal diabetes on Manitoulin Island.

This notion is well supported in the literature (Ferreira & Lang, 2006; Waldram et al., 2006; Joe & Young, 1998; Kelm, 1998) but it has not commonly been encountered or articulated by Aboriginal peoples themselves in the way that some of the participants in this study were able to do. I consider this to be a positive finding suggesting that perhaps some Aboriginal peoples are beginning to realize that they are not necessarily to blame for having developed diabetes and that forces beyond their control and as a consequence of being colonized are at play.

Throughout many of the interviews examples of what represented traditional foods or ways of eating were shared. In chapter four a significant amount of the analysis was attributed to discourse surrounding traditional foods. One of the reasons for this was that traditional foods were often provided as an example of Aboriginal culture probably only second to the importance of language. Because there was often an association between food and diabetes, the importance and prominence around traditional foods was reflected in the data.

The interpretations also seemed to vary in terms of what was considered to be traditional. Although many of the participants shared examples of what they believed to be traditional foods there clearly was no consensus. In reviewing the literature on how traditional foods are defined this was not surprising. The way in which some of the participants in this study characterized the difference between European and traditional foods was not always in

keeping with what is known in the literature, that is, what some of the participants in this study viewed as or characterized as European ways or foods had in fact been practiced by some Aboriginal peoples or part of their diet prior to contact. An example of a food that was often associated as being European by some of the participants in this study were potatoes (Weatherford 1989). As Kuhnlein and Receveur (1996) suggested “traditional food systems of indigenous peoples are defined as being composed of items from the local, natural environment that are culturally acceptable” (Kuhnlein and Receveur, 1996: 417). This rather generic definition might help to explain why representations of what constituted traditional foods seemed to vary so much amongst the participants.

In some cases the interpretations and examples clearly consisted of what I would consider a hybrid form of traditional food such as the example provided by the following participant: “...*real moose burger and deer burger or, or any kind of burger like that, then I would say they were traditional food and like I just sent my sister to go get me some Hamburger Helper. But the thing about it is, I'm gonna use it with moose meat*” (P 9).

Wazayatawin (2005) contends that “rather than viewing our contemporary diets as a consequence of colonization, we have increasingly and uncritically accepted this change in diet, even incorporating many unhealthy foods into what we deem ‘traditional’ (Wazayatawin, 2005: 78). This last example certainly is a good example of that.

It was also interesting yet not surprising to note that none of the participants who were interviewed gave accounts of ever having exclusively relied on traditional foods in the past and even less so presently. The age of the participants was likely a factor. All of the participants were born after World War II and had all been raised in an era in which European contact and

influence had been well established as well as increasing access and availability of market foods. Regardless of this fact the link between culture and food often seemed important for many.

While some appeared to somehow be more connected with the land others gave the impression of seeming disconnected or becoming disconnected from their culture in a number of ways but especially when it came to eating. Socha et al. (2012) found that “loss of connection to and knowledge about the land, and reliance on foods and medicines of the white North American society now contribute to high rates of illness, particularly diabetes” (Socha et al. 2012: 8). This was manifested in the accounts of participants who seemed to willingly reject the consumption of traditional foods either as a result of losing a taste for this type of food or as a result of not having been raised or exposed. From the interviews it was clear that for some the imposition had taken place when welfare was introduced to Aboriginal peoples leading to the creation of dependence.

For these as well as others who still incorporated Traditional foods within their diets what seemed quite clear was that over time a dependence on Western foods had developed. It is quite obvious throughout the literature that over time Aboriginal peoples far and wide have relied less on Traditional foods and become more and more dependent on Western foods (Socha et al., 2012; Waziyatawin & Yellow Bird, 2012; Waldram et al., 2006; Wilson and Yellow Bird, 2005; Kelm, 1998). This increased reliance on Western foods has resulted for some into a sense of powerlessness (Manitowabi and Maar, 2012). It could also serve to explain why the reference to traditional foods was often made in the past tense or as something that was no longer occurring or at least not as frequently.

There are a number of factors that have been identified in the literature as having contributed to changing patterns of eating for Aboriginal peoples and even the decline in consumption of traditional foods including the characteristics of individual communities, living on reserves, exposure to alternative food choices, the media, education, and even changing demands being placed on individuals' time and energy (Kuhnlein, 1992). In addition loss of cultural knowledge which has often been associated with attendance at residential schools, religious influences, and increasing urbanization have also been associated with influencing the access to and consumption of traditional foods. All of these factors could be said to have resulted from European contact and the ensuing colonization of Aboriginal peoples. Most if not all of these factors could also be said to have impacted the majority of the participants in this study either directly or indirectly.

According to Moffatt (1995) there is clear evidence of changing patterns of eating which are linked to a loss of skills as a result of having to attend school as well as through the introduction of various Western foods. All of the participants in this study had at some point in time attended schools which for some were residential schools. These experiences which impacted the ability to be able to rely on the land eventually led to the transition of "a cash economy and the purchase of food" which is problematic for many Aboriginal peoples who tend to disproportionately experience poverty which ultimately impacts what foods can be purchased. This coupled with a decreased reliance on traditional foods can lead to nutritional deficiencies which can impact the health and well-being of Aboriginal people (Moffatt, 1995).

Interestingly enough none of the participants in this study appeared to make a connection between the environment and traditional food sources. There was more emphasis

placed on other factors such as access or not having the skills to live off the land as explanations for decreased traditional food consumption or in some cases no consumption at all. There was often a connection made between culture and food as well as the notion of living off the land. Some of the participants seemed to somehow remain connected to the land while others appeared disconnected.

The ensuing disruption, especially as it relates to ways of eating and the resultant food insecurity has been even further compounded by the fact that many Aboriginal people are poor yet another outcome of oppression, marginalization, and colonization (Raphael, 2009; Reading, 2009; Reading and Wien, 2009; Raphael, 2007). Although none of the participants in this study made reference to poverty specifically or considered themselves as poor the fact that some had limited financial resources was noted and often impacted their access to food, especially Western foods which were often considered expensive. *“I’m in the grocery store all the time you know for fresh fruits, vegetables, stuff like that. It’s very expensive I would think for somebody on a limited income. Very expensive to have the milk and uh everything to meet your needs and the diet itself.”* (P 12)

This was further compounded by the fact that a few, not many of the participants, found that following a diabetic diet in particular added additional costs to the purchase of foods:

You know, but another thing when it comes to eating, like a lot of Native People can’t buy all these foods that are there, that needs to be eaten for diabetes. Like you need salad, lettuce, or you know stuff like that. But, umm, somebody else that doesn’t have diabetes in that family can eat every other thing. So they almost have to buy two sets of groceries to feed themselves coz they don’t have no money. A lot of people don’t

have jobs. They struggle to get food so they can't really keep up with the nutritionists that come into your communities. They tell you to eat this, they tell you eat that but they're gonna go home and eat something else because they can't afford what to buy with what the nutritionist said. (P 2)

Financial means not only impacted the ability to purchase Western foods but for some it also impacted their ability to even be able to rely on the land or traditional foods through hunting:

Because we live here near the city now and have less access), it's hard for some young people to get uh, out in the bush to hunt and they don't know how to hunt ... there was no hunting experiences and well, I think because uh they don't have guns or hard time to get guns and people aren't, some of them live on on uh low incomes and no vehicles to get out to go hunting (P 11).

Having a limited income or resources was certainly noted as a factor that might ultimately contribute to food insecurity. In this case the food insecurity not only applies to the ability to purchase Western foods but also one's ability to be able to hunt or fish, that is, live or rely off the land. It has clearly been demonstrated in the literature that food insecurity as a result of low income can lead to developing a chronic illness such as diabetes as well as obesity, anxiety and depression (Ferreira & Lang, 2006; Syme, 2004; Joe & Young, 1998; Kelm, 1998).

What was interesting to note was that in considering the demographics of the participants in this study it is apparent that many were either employed and several had retired from work. This could suggest that this particular sample was made up, for the most part, of

individuals who would not be considered to be of low socioeconomic status thereby explaining why financial constraints did not appear to be more of an issue.

The link between colonization and creating inequities and marginalization which often perpetuates poverty was not always evident for the participants in this study. This is consistent with some of the work that was done by Chauhan and Weitz (2009) who contend that “poverty is rarely highlighted” in the diabetes research literature as a causal factor but rather “explanations for diabetes among poor people overwhelmingly emphasizes the features of the patients” (74). Although individual risk factors are an important consideration the role that poverty may play was not always evident. Consistently the findings from this study also appeared to demonstrate a greater emphasis is being placed on the individual’s role versus that of society at large when it comes to developing diabetes.

Some of the participants seemed to welcome the changes in ways of eating while others saw it more as an imposition that was ultimately beyond their control and required them to somehow have to adapt or conform. What also seemed to emerge was the idea that going back to the ‘old ways’ of doing things was either not possible or in some cases even welcomed: *“We can’t go back to the way things were, I don’t think that’s possible”* (P 1). A link was made by several of the participants between these changes and adaptation and the increasing incidence of diabetes in their communities. This can certainly be confirmed by Earle (2011) who affirmed that “unhealthy diets and physical inactivity have been identified as two of the three most important modifiable risk factors for the development of chronic disease. Aboriginal peoples in Canada have undergone a significant nutritional transition whereby traditional diets and associated physical activities have been replaced with patterns of consumption that

increase the risk of developing chronic disease” (Earle, 2011: 6). It could ultimately be argued that food insecurity has occurred as a result of colonization (Socha et al., 2012).

When it came to eating, the ease of access to modern conveniences such as market or Western foods had been completely embraced. For some it was a conscious decision because they did not want to put the effort into having to hunt or fish while for others it was as a result of having limited to no access to the land to be able to access more traditional foods. What was interesting to note was that in spite of knowing that Western foods had likely contributed to developing diabetes (Kuhnlein, 1993), they still opted for this approach. Even the cost of food which for some was an issue it still did not seem to encourage them to consider the incorporation of more traditional ways of eating into their diets. It appeared that the appeal of modern conveniences had won out over the potential benefits of eating more traditional foods.

A link between malnutrition and the increasing dependence of Aboriginal peoples on ‘store’ or Western foods has been well established. This increased dependence transpired as there was a move “away from more nutritious ‘country foods’ like fish, game and berries” (Mosby, 2013, 155). The changes in diet date back several decades and its impact was captured in the following passage from a 1946 publication of the Canadian Medical Association Journal: “They have abandoned the native eating habits of their forefathers and adopted a semi-civilized, semi native diet which lacks essential food values, brings them to malnutrition and leaves them prey to tuberculosis and other disease. The white man, who unintentionally is responsible for the Indians’ changed eating habits, now is trying to salvage the red man by directing him towards proper food channels” (Moore et al., 1946, 226). Apart from appearing to refuse assuming responsibility for the outcome I would argue that the preceding quote is

quite accurate and certainly helps to explain at least in part the changes that have occurred in Aboriginal peoples' diets and the negative outcomes such as the development of certain chronic conditions.

This notion is further supported by Waziyatawin (2005) who stated: "Europeans and Euro-Americans maintained their sense of superiority and forcefully imposed their ways, including their comparatively unhealthy diets, upon us. This has only served to deteriorate the health of our people...Our bodies clearly have not benefited from colonization" (68). It is quite obvious to see why many of the participants in this study ultimately suggested that when it came to changes in Aboriginal peoples' diets there really was little if any choice in the matter and the only possible solution was to learn to adapt to the new ways that had been imposed. It's quite interesting and ironic to note that in spite of the fact that even so many years ago there was a recognition that traditional ways of eating or 'country foods' as expressed by some was likely healthier that there was still a push towards promoting Western foods and ways of eating on Aboriginal peoples (Socha et al., 2012; Waziyatawin & Yellow Bird, 2012). The reason for this was that ultimately the goal was to assimilate and integrate Aboriginal peoples into the Canadian population (Mosby, 2013). One of the many ways of accomplishing this goal was to influence ways of eating to the point of changing them altogether in favor of adopting more Western ways ultimately creating dependence. Manitowabi and Maar (2013) recently concluded that "colonization and power imbalances have led to poorer food choices, less physical activity, and generally a sense of unwellness in the community, a general loss of *mnaamodzawin*"(172).

The establishment of the reserve system also played a role in impacting the way Aboriginal people ate by essentially ensuring that they were cut off from many food sources

and resources that they had previously been able to access quite freely prior to European contact (Mosby, 2013; Kelm, 1998; Joe & Young, 1993). In addition and in most cases the lands often set aside for reserves was not suitable for agriculture (Kelm, 1998; Ross, 2014; Waldram et al, 2007). The outcome of European contact and such colonial thinking led to the disruption in the way Aboriginal peoples used to live. “These acts of invasion and colonization meant a total disruption of Indigenous ways of life and tremendous loss of life” (Wazayatawin, 2005: 69). This was also perpetuated in residential schools where children who had often been forcibly removed from their families, communities and ways of life were fed diets primarily made of starches and fats which had not typically been a huge part of the diet. They were also introduced to dairy products, livestock, as well as sweets all of which would not have been part of their diets growing up. In addition to the introduction of foreign less healthy foods children who attended residential school were often deprived of a sufficient amount of food and often went hungry (TRC, 2015). Similar outcomes to these were evident in some of the participant narratives.

In the end, it could be argued that for some of the participants, their diet has become completely ‘westernized’ and devoid of any form of traditional foods. The advantages of convenience, choice and in some cases taste take precedent in spite of knowing that a traditional diet is likely a healthier choice for them however as a result of contact and European influences the traditional way of eating is becoming less common. On a more positive note there was a sense that some of the participants were at least open to incorporating traditional foods into their diets but no real sense that there was a move or even interest in a more decolonized diet.

The notion of no going back also fared prominently in that many believed that it was either impossible or not desirable to go back to the way things may have been in the past. In returning to the concept of culture as not being static it is interesting to note that some of the participants, as previously stated, gave the impression of being disconnected from their culture and the land. Although they did not make a link between this connection and Aboriginality, I was left with the impression that perhaps some of them felt a bit less Aboriginal than others, especially compared to those who reported some form of connection to the land. This finding is much in keeping with some of the literature that tends to present culture as a static unchanging concept. The reality is that it is not realistic or likely possible for Aboriginal culture and practices to remain unchanged from the last decades to centuries because as many authors have suggested culture is continuously changing and evolving. Culture is subjective and what is occurring today. Some of the participants seemed to suggest that since they did not hunt or fish or access and live off the land or eat traditional foods anymore they were somehow disconnected from the culture. This way of thinking has likely been influenced as a result of colonial contact, prominence and dominance.

7.3 *Developing diabetes*

The sense that diabetes was inevitable was ever present throughout most of the interviews was another key finding in this study. In reviewing the literature there does not appear to have been much work done in exploring this particular phenomenon especially when it comes to Aboriginal peoples. This perception is therefore considered to be one of the many key and unique findings from this study. In addition, much in keeping with the literature that deals with theories of causation, the participants from this study appeared to view diabetes

more as an individual problem rather than one that also had external contributing factors which were often out of their control. This would appear to suggest that there was often a lack of awareness on the part of many of the participants of the significant role that colonization had played in contributing to the high rates of diabetes amongst Aboriginal peoples.

In addition to feelings of inevitability the participants often freely shared their beliefs about how they had come to develop diabetes. In reviewing the literature it is not uncommon to come across work that has focused on theories of causation or explanatory models with respect to diabetes (Manitowabi and Maar, 2013; Poudrier, 2007; Rock, 2003; Sunday et al., 2001; Garro, 1995). There appear to be two schools of thought on the development of diabetes, that is, one that tends to focus on the individual or body and another that suggests that external forces are likely just as if not more responsible. The former tends to place the responsibility or blame on the individual whereas the latter considers the fact that there often exist factors which are beyond the control of individuals themselves (Poudrier, 2007; Rock, 2003; Garro, 1995).

Sunday and colleagues (2001) referred to these two perspectives as biomedical and Aboriginal narratives. The biomedical stance tends to place emphasis on lifestyle factors and choices at the individual level whereas Aboriginal views tend to consider the role of genetics. For some of the participants in this study there appeared to be an internalization of the colonial construction of Aboriginal peoples, that is, that somehow Aboriginal peoples are genetically inferior and their bodies are not suited for modernization which has translated into high rates of type II diabetes. That being said a focus on genetics at the exclusion of considering other socio-political factors could also be viewed as limited. The findings in the study related to the

development of diabetes appear to suggest that participants appear to have adopted one or the other of these two perspectives and in some cases a combination of the two.

The role that lifestyle and individual choices played in assigning responsibility was noted in several of the interviews. This was most often associated with changes in diet or ways of eating. In spite of the fact that changing ways of eating had been imposed there was still a sense that many of the participants assumed some of the responsibility for having developed diabetes. That being said it is also quite evident in the literature that individuals do bear some responsibility and to some extent do have some control over lifestyle choices (Rock, 2003). The argument to be made in the case of Aboriginal peoples is that perhaps as a result of the strong influence of colonial forces self-determination might be limited by forces beyond an individual's control. Examples of these limitations could include but are not limited to access to the land and traditional foods or wild game.

Participants who had not been exposed to more traditional ways were more likely to share that their poor eating habits were responsible for their diabetes. They also seemed to be implying that perhaps if they had known differently they may not have developed the illness choosing to assume responsibility rather than consider the possibility that there might exist external forces that are beyond their control and that are equally if not more responsible for their developing diabetes. This suggests that for some of the participants consideration of diabetes beyond the biomedical perspective to consider some of the socio-political impacts of colonization has not yet entered into their consciousness. One exception to this is perhaps found in the following excerpt: *“what I’ve been hearing is that long time ago we ate off the land and the government brought in welfare and all that, that’s why we’re all, all of a sudden*

diabetic...”(P 18). According to Sunday and colleagues (2001) some Aboriginal peoples have linked the development of diabetes to a poor diet which resulted as a consequence of European contact and the introduction of Western foods. One could make the argument that the imposition of welfare is considered by some at least as a political impact which contributed to the increased prevalence of diabetes. These representations are a good example of being able to attribute the development of diabetes to both internal and external causes.

The importance and significance of gender roles, particularly the role of women in this study was also present. The significant and often prominent role of women when it came to eating and medicine seemed quite significant. Ross (2014) contends that as a result of colonization the role of women in Aboriginal culture was seriously affected by being removed from positions of power and authority. This did not appear to be the case in this study. There were numerous examples of women occupying key roles within their families and communities. What did seem significant however was the role that women played with respect to the development of diabetes.

Many of the participants believed that diabetes was inevitable and genetic, something that was handed down through the generations or as some put it they were born with. The woman's role in the passing down of diabetes although not always explicitly stated was often implied and significant. This finding is somewhat unique in that I was not able to identify any previous work that explored the role and meaning of gender when it came to the development of diabetes in Aboriginal peoples. This notion would certainly merit more exploration.

Poudrier (2007) has long argued against the 'geneticization' of Aboriginal diabetes because although there is “no doubt, genetic elements involved in the onset of obesity and

diabetes” exist placing too much emphasis on this perspective often comes at the expense of overlooking other socio-political factors associated with colonization that are just as if not more likely responsible for the increased rates of diabetes in Aboriginal people (238). Her perspective is a good example of the need to promote Aboriginal world views with respect to the development and contributing factors associated with type II diabetes. According to Manitowabi and Maar (2013) “ discourse of Aboriginal diabetes must not be strictly tied to a biomedical conception of diseased biological bodies, but must also link historical and political processes outside the body as bearing relational consequences within the body” (172).

In the end it seemed inevitable for most of the participants in this study that diabetes would come. There was some evidence of considering preventing it in the first place but more so at the individual level. There seemed to be little if any discourse around the need for a change in policies that have and continue to contribute to unique factors that predispose Aboriginal peoples to have higher rates of diabetes than the general population. Participants often seemed quite ready to assume complete responsibility which is not surprising since main stream approaches to managing diabetes tend to place the onus on the individual rather than consider socio-political factors such disparity and inequity ultimately brought on by colonization (Reading, 2009; Reading and Wien, 2009; Ferreira & Lang, 2006).

Once again the idea that developing diabetes was somehow not a matter of choice whether self-imposed or as a result of external forces seemed to emerge. The sense of having to adapt once again seemed evident for many of the participants in this study. The fact that there seem to be awareness and the ability to verbalize the impacts of colonization on the development of diabetes was present in some of the interviews. This last perspective could be

seen as a unique finding since most of the literature reviewed on the topic often is theoretical in nature. The participant excerpts used to substantiate these perspectives could be seen as offering new insights and proof of the impact of colonization directly from Aboriginal peoples themselves using their own words.

According to Wiedman (2006) “diabetes and associated metabolic disorders were believed by many to be inevitable consequences of genetics and the modern lifestyle. We now know that by striving for healthy lifestyles, Indigenous communities can reduce the diabetes rate and possibly prevent it from occurring” (511). The idea that needs to be advanced here is the notion of healthy lifestyles in its broadest sense. Too often there is a tendency to focus on the impact of modern lifestyle and diets and attributing much if not all of the blame to modernization as it relates to Aboriginal peoples.

Perhaps what might be considered is that a healthy lifestyle is one that can include both traditional and western ways of eating thereby promoting the notion of balance. This is an important consideration since as it has been clearly demonstrated in this study, that modernization is a reality and it is not possible to go back to the way things once were. As Alfred (1999) contends ways of living as a result of colonial encounter and impact have been forever changed. It is not a question of one or the other. The idea being advanced, which might be considered to be culturally safe, is that it is not necessary to go back to the past but rather consider inventing a future that incorporates the best of both worlds in an attempt to promote healthy ways of living. In doing so, new definitions and conceptualizations of what it means to be an Aboriginal person living with type II diabetes may begin to emerge.

7.4 *Diabetes Care*

Accessing diabetes health related services can often be challenging. For Indigenous peoples this reality is perhaps even more significant. Throughout the course of the interviews the majority of participants automatically began sharing about their diabetes care experiences. Some provided examples of what they considered to be traditional forms of medicine and healing practices while others appeared to focus more on Western medicine.

On several occasions reasons or justifications were provided by the participants to explain why they might select one approach over the other. These explanations consisted of examples of how their choices had been influenced either as a result of not having been exposed to Traditional ways or having had or heard of a bad experience. Several participants believed that Traditional and Western medicines could complement one another while some held the belief that the two should and in some cases could not be combined.

The impact of European contact once again was ever present in the participant interviews surrounding their accounts of accessing and navigating the health care system. It was clear that prior to contact there were systems and practices in place that were eventually disrupted in favor of Western forms of medicine. Ultimately this seemed to result in fostering a dependence on Western medicine over Traditional medicines and practices.

In terms of health care, especially as it relates to diabetes, many of the participants in this study believed that Western medicine was superior and in spite of its many shortcomings, was for the most part the only option available when it came to treating diabetes. This appears consistent with some of the findings in a narrative inquiry exploring the self-care experience of Aboriginal peoples in British Columbia conducted by Barton (2008) who discovered that the participants in

her study also seemed to consider ‘mainstream’ diabetes treatment to be the most appropriate. In spite of the fact that Traditional approaches for treating type II diabetes are limited, I do believe that Traditional healing philosophies which tend to be more holistic in nature could further enhance the quality of type II diabetes care for Aboriginal peoples.

This was a particularly interesting finding given that many of the participants’ accounts of dealing with and navigating through the health care system were fraught with examples of feeling judged and controlled as evidenced by the perception of having to do what you are told. It even appeared that this was the case whether accessing care from within the community or from outside agencies. Once again this outcome is quite typical in a colonial environment. What is troubling is that many of the participants had come to believe that there were no other options for them when it came to diabetes care, a notion that has likely been imposed upon them by Western educated health care providers. Alternatives could include health care that is designed in a more culturally safe manner or perhaps even greater access or awareness about traditional methods available to treat diabetes.

There was a sense from many of the participants that when it came to diabetes care, there seemed to be few choices available to them in terms of treatment and that they needed to adapt or conform to a system of health care that at times seemed at odds with their beliefs. According to Giles, Findlay, Haas, LaFrance, Laughing, and Pembleton (2007) “there is a concern among Aboriginal communities in Canada that conventional approaches to the treatment of diabetes are ineffective in part because they fail to recognize the local Aboriginal perspective on the causal determinants of diabetes”(562). The findings in this study seem to support this contention. Ross (2014) suggests that “the healing challenge for aboriginal people

demands the best approach from all sources”(262). In other words there is certainly the view that Western and Traditional medicines can complement one another. Several of the participants appeared to share this belief.

The role of Traditional medicines and practices was frequently encountered throughout most of the interviews. The discourse surrounding Traditional medicines often seemed to raise as many questions as it answered. Just as some have questioned the impact and even the extent of colonization on Aboriginal peoples (Flanagan, 2012) some also appear to question the legitimacy of traditional medicines and practices suggesting that these are nothing more than ‘quackery’ (Widdowson and Howard, 2008). These scholars have often been criticised for their excessive conservative perspectives downplaying the impact of colonization.

It was not surprising to observe that many of the participants in this study viewed Western medicine as their only option when it came to diabetes care given that up until World War II it was essentially non-existent (Ferreira and Lang, 2006; Joe & Young, 1998). Consequently it has been further argued that there likely never existed any traditional medicines or treatments for diabetes (Widdowson and Howard, 2008). The problem with this statement is that since the presence and even prevalence of diabetes is unknown or at least has been undocumented therefore an argument could be made that medicine was not needed for something that may not have existed.

With the advances in ethnobotany such as evidenced in the recent body of works published by a group of scientists from the Université de Montreal, McGill University and the University of Ottawa seem to suggest the contrary (CIHR, 2013). Through the application of Western science methodology in the form of ethnobotany scientists are beginning to uncover

and discover that medicinal plants commonly used by some Aboriginal groups in the past may in fact possess ‘anti-diabetic’ or hypoglycemic properties and could play a role in the treatment of diabetes after all.

This group of researchers established agreements to work with various Cree Aboriginal stakeholders from the East coast of James Bay in the province of Quebec to study the anti-diabetic medicines derived from plants traditionally used by the Cree (CIHR, 2013). This collaboration began in 2003 with funding from the Canadian Institutes of Health Research (CIHR) and continued up until 2011. During this project approximately twenty six papers were published by various researchers working in the field of Aboriginal anti-diabetic medicines. Although it is beyond the scope of this thesis to enter into a discussion and review of this body of work, it was presented in order to demonstrate that in spite of its critics, work in the area of exploring the medicinal properties of certain traditional plants used by the Quebec James Bay Cree in the past appear to possess anti-diabetic properties which could prove useful and provide alternative and or complimentary therapies for Aboriginal peoples living with type II diabetes wishing to explore alternatives to the conventional Western bio-medical treatments for diabetes. Although relatively new findings, this extensive body of work might offer hope and seem promising for those wishing to promote and further advance the possible role of Traditional medicines in the treatment of diabetes. On several occasions it appeared that some of the participants seemed open to the idea and even welcomed the possibility.

Many of the participants reported being faced with the question of legitimacy when it comes to Traditional medicines and practices. Durie (2004) has suggested that just as “Indigenous knowledge cannot be verified by scientific criteria nor can science be adequately

assessed according to the tenets of Indigenous knowledge. Each is built on distinctive philosophies, methodologies, and criteria” (1138). He goes on to suggest that the ongoing and longstanding debates about their relative benefits have only served “as distractions from explorations of the interface, and the subsequent opportunities for creating new knowledge that reflects the dual persuasions” (1138).

Some of the participants appeared to question the legitimacy themselves. For some the observed changes in traditional medicine practices led them to question their efficacy. An example of this was advanced by one of the participants who seemed to suggest that contemporary traditional healers were somehow not as knowledgeable as their predecessors. Certainly the fact that sharing and passing down of traditional knowledge from one generation to the next could help to explain why some Aboriginal peoples themselves has also come to question the practice (Roos, 2014).

The problem with recognizing or being open to incorporating Traditional medicine with Western medicines seems to rest primarily outside of the communities. Non-Aboriginal health care providers who may not be familiar with or well acquainted with Aboriginal peoples and their culture are more likely to reject or question the legitimacy of Traditional medicines thereby giving their patients the impression that they have no other option but to adhere to Western medicine, essentially requiring them to ‘do as they are told’.

It is interesting to note that according to a publication by Shroff (2011) Traditional practices have been around for centuries whereas ‘allopathic’ or Western medicine has really only “held its influential position” for about one hundred years (130). Similarly Waziyatawin and Yellow Bird affirmed (2005) that “Indigenous knowledge regarding medicine and healing

was extremely sophisticated prior to colonization, and in some cases still is...Nearly every illness also had an Indigenous remedy...it is estimated that about 25 percent of the world's medicines today came from knowledge held by Indigenous peoples" (68). In spite of Western medicine's relative youth it certainly has positioned itself as the dominant force when it comes to health care, a position originally advanced by such scholars as Foucault (1963) and Illich (1976). It is encouraging to note however that in spite of Western medicine's assumed dominance Shroff (2001) believes that "medical pluralism is experiencing a renaissance" (130).

Maar (2004) suggested that "medical pluralism has not been part of the development of Canada's health services" which is why up until recent years there was little to no support for Traditional medicines or practices when it came to health care (60). She goes on to affirm that "traditional healing practices have evolved based on Aboriginal cultural frameworks, not western primary care models" (60). Although there has been an increase in the availability of Traditional healing practices and medicines at the community level as a result of initiatives such as the Aboriginal Healing and Wellness Strategy in 1994, many of the benefits of these types of initiatives and services have not necessarily benefited all Aboriginal peoples given the possibility that many may continue to have to access health care services outside of their communities either out of choice or out of necessity.

I would suggest that based on some of the findings from this study that this may not necessarily be the case for all Aboriginal peoples living along the North Shore of Lake Huron. Since the actual availability and uptake of traditional healing services was not determined, it is not possible to make this determination. A clear indication that healthcare is still highly colonized is evidenced by the established hierarchy and the fact that Western medicine is often

viewed as the ideal. It could be argued that health care has never been un-colonized since it is primarily based on the “colonizer’s” culture. This was certainly evident throughout the discourse of most of the participants in this study.

“And they have to understand what, like Native People, Native People are, I think there’s that uh, I, I’m more powerful then you. I think I have an attitude too, that, you know that they’re the doctors, they’re the nurses, and So they treat you like that, they don’t treat you like a human being, not the way you should be treated. I think that’s one of the biggest things is to know that you’re Native. Not look down on you. I think that’s what’s happening to a lot of our people because of that, colonization That’s where it all comes in” (P 7).

During interviews with Aboriginal peoples living with diabetes Garro (1995) discovered that often “input from physicians, nurses and others greatly influence how people talk about diabetes...the message conveyed by the biomedical practitioners...is primarily one of individual responsibility”. This biomedical approach seems to explain why so many of the participants in this study felt the need to do as they were told. This type of messaging can also shift the burden of responsibility from external colonial forces and place them squarely onto the shoulders of the individuals themselves.

The notion of unequal power relations often seemed significant and recurring for many of the participants. For some these types of unhealthy relationships evolved as a result of having attended residential school. A possible outcome of this type of approach to providing health care to Aboriginal peoples has been equated to ‘second class treatment’ (Allan and Smylie, 2015).

This common perception seemed to some extent influence the choice for many of whether they would consider accessing or incorporating traditional medicines or practices when it came to their diabetes. There was a need for some to somehow seek and gain the approval of their health care providers before engaging in Traditional practices or taking traditional medicines even though it was often suggested that Traditional medicines were more holistic and in keeping with Aboriginal worldviews. The idea that Western medicine was somehow superior because it was studied compared to Traditional medicine which is simply handed down through the generations was also encountered. Once again this was not surprising given the emphasis that is placed on Western medicine often at the expense of being open to or considering Traditional medicines or practices.

It has been suggested by some that “Europeans had two major impacts on indigenous systems of medicine. First genocide of indigenous peoples-using techniques such as warfare, the introduction of alcohol, residential schools, spreading diseases-causing death of millions of people and the destruction of their systems of health care (although some survived) and second, the introduction of holistic systems of health care” (Shroff, 2011). I would argue that the second has yet to take place. The current primarily bio-medically focused model of diabetes care could hardly be viewed as holistic given its focus on the physical often at the expense of other aspects of the individual such as social, emotional and spiritual dimensions.

The findings related to accessing treatment for diabetes for the participants in this study appear to confirm that the care they are often receiving could be considered to be colonized and in some cases culturally unsafe. There is a need to move away from a model of diabetes care that is predominantly focused in the biophysical aspects of the illness often focused on diets

and medication to one that is more holistic and respectful of Aboriginal world views and beliefs (Ross, 2014). The need to be open to and promote the notion of medical pluralism that is, exploring the complimentary nature of both Traditional and Western medicines has yet to take place.

For those who were open to combining Traditional and Western ways there was a clear sense that Traditional medicines and practices, for the most part, were viewed as complementary. It even appeared as though most believed that Western medicine was essential for anyone living with diabetes. This notion was supported by some accounts of individuals who had abandoned Western medicine in favor of exclusively relying on Traditional medicines or practices and ended up sicker or perhaps even dying. Not one of the participants ever seemed to suggest that diabetes could be treated with Traditional medicines alone, at least not at this point in time. Rather there was a sense that under the right circumstances the two could work together and ultimately benefit those who are open to and willing to incorporate Traditional and Western ways.

Another key finding in this study is the idea that as a result of colonization it became quite evident that the participants in this study have had to adapt to new realities when it comes to the way they eat as well as when it comes to the medicine that they chose. What was particularly interesting to note is that this adaptation, at least when it comes to diabetes, appears to have taken two different approaches.

The first method of adapting is one in which some of the participants have embraced Western ways of doing completely and appear to have abandoned more traditional practices. In chapter four this process was conceptualized as a form of disconnecting from the land and

culture. It is without question that this form of adaptation occurred as a result of colonization and Western influences. For many it was not only a question of not being able to return to pre-colonial times but perhaps even a question of not wanting to.

The second method of adapting is one in which although there appears to be a recognition that things can never return to a pre-colonial state of being, the suggestion appears to be that combining the best of both Traditional and Westerns ways of doing is possible. This second method of adaptation could be viewed as taking a decolonizing approach to diabetes care. Participants who seemed more connected to their culture and to the land were more likely to consider the incorporation of Traditional foods into their diets as well as Traditional medicines or practices into their health care. What was interesting to note is that they seemed to recognize the limitations that had been imposed on them as a result of colonization.

It became quite evident that for most of the participants in this study that over time many of the Traditional practices when it comes to eating and health practices have changed. Many of the participants had notions about pre-contact times and ways of living and how these had changed as a result of European influence. As a result there was no consistent view amongst the participants in terms of how and why each of them had come to believe and in some cases adopt as their worldviews.

As Little Bear (2000) contends: “both the colonizer and the colonized have a shared or collective views of the world embedded in their languages, stories, or narratives...No one has a pure worldview that is 100 percent Indigenous or Eurocentric; rather, everyone has an integrated mind, a fluxing and ambidextrous consciousness, a pre-colonized consciousness that flows into a colonized consciousness and back again. It is this clash of worldviews that is at the

heart of many current difficulties with effective means of social control in postcolonial North America. It is also this clash that suppresses diversity in choices and denies Aboriginal people in their daily lives” (85). His explanations help to shed light on why and how colonization has impacted values, beliefs, and choices that have been made when it comes to eating and health care choices.

The notion of a more holistic view of health that extends beyond the physical to include other dimensions such as the social, spiritual and intellectual was evident for many of the participants. This holistic perspective was at times implied while at other times stated more explicitly by some of the participants. I would suggest that the clients who seemed more connected to their land and culture were more likely to consider health from a more holistic perspective and it was through these perspectives that the idea of a decolonized model of diabetes care appeared to emerge. The concept of health from an Aboriginal perspective which was introduced in the beginning of this thesis remained important and present. Although it was not explicitly referred to in the discussion surrounding the conceptual framework for this work the fact that the topic of diabetes was a main focus made it so that the concept of health was implied.

I believe that it is important and significant, if not telling, to point out that very little if any attempts at defining and conceptualizing the notion of health was made by the participants in this study. It is perhaps not surprising to note that much of the discourse seemed to focus on diabetes as an illness or as a reason for not being healthy as evidenced in this participants statement: *“I think being healthy means doing whatever your mind allows you to do. That’s healthy. I’m not healthy because diabetes has slowed me down” (P 21).*

Although some of the participants briefly addressed the notion of living in balance, their feelings about living with diabetes and what it meant were quite abundant. I was not able to get a clear sense of what it might mean for them to be healthy. Perhaps the notion of health could have been better explored in future research.

In returning to the concept of self-determination which is understood in its broadest sense as promoting equality in the decision making process when it comes to diabetes care, one could argue that for a number of the participants in this study this was not always the case. A number of examples were provided through participant excerpts in which participants felt they had to do as they were told or at times feared discussing alternate or complimentary forms of health care. A lack of self-determination and equality with respect to diabetes care certainly seemed to be lacking.

Finally in relation to cultural safety, which has been promoted as an interpretive lens through which to consider and reflect on policies and practices that may impact and contribute to power imbalances and inequitable relations within the health care context, I believe that not unlike in the area of self-determination, the participants in this study often seemed to describe health care encounters that would definitely be considered to be culturally unsafe and for much of the same reasons. Evidence of cultural safety appeared to often be missing within the context of diabetes related encounters for several of the participants in this study.

The adaptation of a complementary approach by some which incorporates the best of both worlds, that is, Traditional and Western ways when it comes to diet and medicine for diabetes could be viewed as a form of decolonization which is underpinned by self-determination. This adaptation could also be seen as representing a form of cultural revitalization

and one that can be promoted with cultural safety. The process of decolonization ultimately rests with the individuals themselves and begins with them.

The implied need for a decolonized model constructed from the analysis of the data once again represents an approach to living with diabetes that has moved beyond the traditional biomedical Western approach to one that considers and incorporates more traditional practices such as diet and medicines. It also demonstrates that there is a movement for some extending beyond the commonly shared perspective that diabetes is an individual problem to one that views this illness from a collective perspective and recognizes the socio-political influences of dominance and colonization as having contributed to its prevalence amongst Aboriginal peoples.

7.5 *Decolonizing the diabetes experience*

Individuals living with type II diabetes require specific treatment plans (CDA, 2013). Ideally each treatment plan should be tailored to the individuals' particular needs and include, in my opinion, a combination of both Traditional and Western approaches. . This is especially important when considering the cultural needs of Aboriginal peoples. Unfortunately most of the attention when it comes to Aboriginal health care is often placed on the physical or bio-medical aspects (Allan and Smylie, 2015; Waldram et al., 2007; Ferreira and Lang, 2006). This primarily Western bio-medical approach to health and diabetes care for Aboriginal peoples is problematic since it based on colonial ideology which can be at odds with Aboriginal ways and views with respect to health and wellness which are often considered in a more holistic manner and strongly influenced by culture (Manitowabi & Shawande, 2011; Ross, 2014).

The notion of decolonization is beginning to receive a lot of attention. Although there has been work done in Australia focusing on the attitudes of non-Aboriginal health care

providers and the promotion of decolonized models of care (Wilson et. al., 2011) the idea of promoting a decolonized model of diabetes care seems to be relatively new. It is my contention that the guiding principles of decolonization which require self-determination as a main ingredient need to be customized or individualized to the particular needs of any given Aboriginal community since it has been well established that diversity exists between them.

According to Browne & Smye & Varcoe, (2005) a decolonized model of diabetes should include the following key elements: i) not losing site of the impact and ongoing legacy of colonization; ii) considering and being critical of the experience of colonization; iii) promoting that the perspective of the colonized be considered above of that of the dominant culture; and iv) expanding the understanding of how race, racialization, and culture are conceptualized in past and present 'post-colonial' contexts. These elements will ultimately inform the decolonized approach being proposed in this study.

The complementary approach taken by some of the participants in this study may represent a form of resistance to colonial domination when it comes to living with and managing their diabetes. The concept of resistance as it relates to Aboriginal peoples is viewed in this context as means of retrieving what once was and remaking oneself. The importance of retrieving one's culture, language, social practices and stories are all examples (Smith, 1999). More specifically, although some of the participants appear to reject traditional ways of eating and medicine others appear to be suggesting that perhaps the two can co-exist and complement one another. There is a conscious choice on the part of some of the participants to refuse to accept the imposition of a predominantly biomedical and Western model of diabetes care in favor of a model that is more inclusive and respecting of different ways of knowing which in this

case include Aboriginal ways of knowing. Perhaps this adaptation and choosing a complementary approach is an example of anti-colonialism and represents as Hingangaroa (2000) described as a proactive position of resistance that is being adopted when it comes to type II diabetes.

Corntasel (2012) contends that colonization is a 'disconnecting force' whereas "decolonization offers different pathways for reconnecting Indigenous nations with their traditional land-based and water-based cultural practices" (89). The method of adapting to a new reality which is seen as complimentary and one that incorporates the best of both worlds could assist some Aboriginal peoples living with type II diabetes along a new path which would facilitate a 'reconnection' with the culture.

The current biomedical Western model of care dominates and until such a time as we begin the process of decolonization, this will continue to be the case. "A shift must occur to make Aboriginal health improvement a reality. This shift requires the decolonizing of Aboriginal health so that the experts in Aboriginal health, name Aboriginal people can voice and action initiatives that address their health issues" (Sherwood and Edwards, 2006: 178). I would suggest that there is a need to 'decolonize' existing attitudes in general, but especially in terms of Western medicine. Although some steps have been taken to this end, clearly there is still some progress to be made. This might promote an environment in which both Traditional and Western approaches could benefit from each other through better integration. In order for this to take place there would need to be a dismantling of oppressive and racist attitudes that evolved during the colonial era. I am not certain that this is even a possibility but it nevertheless should be addressed. I would further argue that until such a time as this 'shift'

occurs, Aboriginal peoples who are disproportionately impacted by diabetes will continue to receive care that it is not culturally sensitive, appropriate, safe or even relevant until such as time as the 'shift' occurs.

The concept of decolonization was an essential and integral part of this study from the very beginning as it served as a lens through which to consider the experience of type II diabetes for the participants. Knowing and appreciating that colonization was ongoing, by considering the importance of decolonization provided me with a framework to determine to what extent colonization was impacting the experiences of living with type II diabetes for these participants. It also permitted me to determine whether their experience was completely colonized or if there was only partial evidence that decolonization existed and if so to what extent. In this case the idea that some of the participants saw the benefits of combining Traditional and Western ways in a complimentary way seemed to suggest that for some at least there was a move away from relying exclusively on a Western biomedical model to one that was more respectful and inclusive of Aboriginal ways of knowing.

It has clearly been demonstrated in reviewing the literature and further confirmed through my interactions with the participants in this study that colonization has impacted them in a number of ways. My aim in conducting this study was to focus mainly on how colonization has impacted the diabetes experience in particular. In spite of being provided with a significant number of examples of negative colonial impact on ways of living, eating, and accessing health care when it comes to diabetes it also became apparent that as my substantive theory appears to be suggesting that some of the participants' adaptation could be interpreted as a decolonizing approach to living and dealing with diabetes.

I believe that some of the participants have found a way to live with diabetes which could be seen as decolonizing. There is a sense that several of the participants have found a way to combine the best of both worlds that is Traditional and Westerns ways, in order manage and live with their diabetes. This approach was not explicitly stated by the participants but rather emerged over the course of analyzing the data.

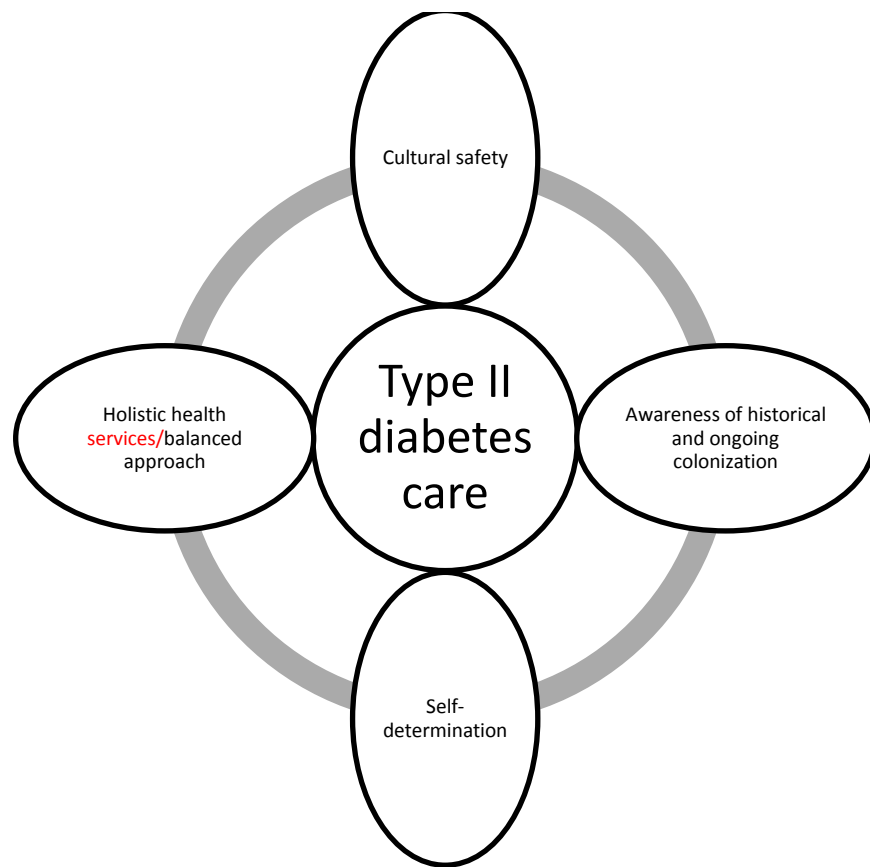
It was my goal while conducting this research to explore the impact of colonization on the lived experience and perceptions about developing type II diabetes for Aboriginal peoples living along the North Shore of Lake Huron. Throughout my many years of experience as a Primary Health Care Nurse Practitioner providing care to Aboriginal peoples it became evident that the traditional biomedical approach often failed to consider or take into account the historical and ongoing legacies of colonization. This failure was quite noticeable during my interactions with the participants in this study through the many examples of how they had changed their ways of eating, how most seemed unaware of how colonization had contributed to the increased prevalence of diabetes but perhaps most notable yet not surprisingly in their interactions with the Western health care system.

The proposed model was constructed from the analysis and interpretation of the data (Figure 1). With type II diabetes at its core, the elements of cultural safety, understanding of the historical and ongoing impact of colonization by health care providers, self-determination which is key to decolonization, and a balanced and holistic approach to health are considered to be essential elements of the proposed model. A model such as this one could be viewed as ‘post-colonial’ or a departure for some from completely embracing the Western bio-medical approach to diabetes care.

This model promotes self-determination and recognizes the possibility that Traditional and Western ways can complement one another. Furthermore it could provide Aboriginal peoples with the opportunity to select a more culturally safe and appropriate model of diabetes care because it acknowledges the fact that colonization has created a system of health care that often fails to recognize, appreciate or even respect Aboriginal ways and world views as potentially contributing to the diabetes experience in a more positive, holistic and culturally acceptable manner. The use of a circular approach with a central theme surrounded by interrelated concepts was deliberate and in part influenced by my understanding of the Medicine Wheel and the notion and importance of balance. I believe that all four of the elements presented in this decolonized model need to be considered in relation to each other and in a balanced manner. Perhaps the elements from this proposed model could someday be incorporated within a Medicine Wheel.

It is important to note that it is was not my intention to provide a detailed description of a decolonized model of diabetes care but rather to highlight what I believe to be the essential elements which could serve as a framework for the development of community specific diabetes care programs and initiatives. In order to promote self-determination it is necessary that Aboriginal communities and individuals who live with type II diabetes lead the discussions on what the actual models will eventually look like. To suggest otherwise would only serve to perpetuate a colonial attitude which I have clearly argued against throughout this thesis.

Figure 1: Proposed model for a decolonized approach to type II diabetes care for Aboriginal Peoples



The findings from this study have helped to shed light on a reality that is often overlooked and not well understood. It was not the intention of this study to explore the common challenges faced by individuals who live with diabetes such as following a diet, taking medication or having to monitor their blood sugar since it is well known that living with diabetes can be challenging (CDA, 2013). I did not spend time asking them what it was like to manage their diabetes but rather I attempted to explore how colonization has impacted the experience and how this is manifested. My intention in conducting this study was to provide the participants with an opportunity to articulate how colonization had impacted their diabetes experience and

perceptions about developing diabetes as well as how they chose to respond and adapt. For the participants in this study changing diets, the development of diabetes and the choices with respect to diabetes care seemed most important. This study sought to explore the interconnection between culture, diabetes, and colonization for Aboriginal peoples living along the North Shore of Lake Huron.

7.6 *Summary*

The preceding three chapters presented and then discussed the findings in relation to both available theoretical and empirical literature. In this last chapter the substantive theory related to the experience of Aboriginal peoples' experiences of living with type II diabetes which emerged from the analysis of the data was presented and the key findings of this study were highlighted and discussed.

My goal was to gain a better understanding of how historical and ongoing colonial practices impact the experience of living with and the perceptions about developing type II diabetes in order to be able to propose a decolonized model of diabetes care. It was my contention at the outset, which was based on my personal and professional experience as a Primary Health Care Nurse Practitioner, that many of my colleagues, especially those who are non-Aboriginal, do not seem equipped to more fully understand and appreciate the historical and ongoing legacies of colonialism. This lack of understanding has only served to further perpetuate and contribute to the provision of diabetes care that could be considered by some as colonized and ultimately culturally unsafe. This reality was especially noticeable in the narratives about some of the study's participant's experiences in navigating the health care system.

Clearly the dominant biomedical approach to diabetes care was ever present and manifested itself in the perception that many, even those who believed in combining traditional and Western medicines, that they required approval from their health care providers and ultimately had to do as they were told. I believe that this approach has contributed to the existing health inequities and disparities that impact Aboriginal peoples in so many ways not least of which are the increasing rates of diabetes as well as other chronic conditions.

In spite of the extensive publications on colonization and cultural safety that have taken place especially over the last couple of decades, it appears that it has had little if any impact on improving the diabetes experience at the very least for Aboriginal peoples living along the North Shore of Lake Huron. Many authors have promoted a decolonized approach to research (Smith, 1999) and education (Cote-Meek, 2010; Battiste, 2000) but no one seems to have advanced the idea of decolonizing type II diabetes.

In the final section I will provide concluding remarks and discuss the implications for future research, identify study limitations and make recommendations with respect to moving forward.

CONCLUSION

In chapter seven the key findings of this study were highlighted and discussed and the substantive theory related to the experience of Aboriginal peoples' experiences of living with type II diabetes was presented. The findings were presented in relation to available literature both theoretical and empirical in order to situate the study. I will now provide some conclusions in relation to the key findings of this study. I will end the conclusion by briefly addressing the study limitations and making recommendations.

Achievement of the study's aims and objectives

In the introduction section of this thesis I presented the aim of this study which was to identify and contextualize issues faced by Aboriginal peoples who live with type II diabetes and to develop a substantive grounded theory that might explain their experiences which in turn could assist in the development of a decolonized model of diabetes care for this population. As previously stated my goal was to merely provide the reader with a framework for this model which included key elements. As I will present in the recommendation section, the actual decolonized model remains to be constructed by the communities and individuals who live with type II diabetes. By exploring the connection between the three main categories of *changing ways of eating, developing diabetes, and choosing your medicine* it appeared that the majority of the participants in this study were demonstrating a sense of not being able to go back to more Traditional times when it came to their diet, developing type II diabetes and ultimately the type of care that was available. There was an ever present sense that most felt the need to adapt or conform in terms of lifestyle, living with an illness and their diabetes related health care services. For some the adaptation was clearly in favor of Western approaches to

diabetes care while for others the notion of combining the best of what both Traditional and Western ways had to offer seemed to promote a more decolonized approach or model of diabetes care. It was from the interpretation of these key findings that the substantive theory which was presented earlier in Chapter Seven was developed. I contend that the objectives and aims of this study were achieved through the discovery and description of the collective experience of the participants which ultimately led to the theory being advanced.

This study contributes to the existing knowledge base of diabetes care for Aboriginal peoples. It will provide some insights into the issues and challenges that often confront Aboriginal peoples who are experiencing and living with type II diabetes in an environment that is primarily Westernized and often insensitive or unaware of the realities of historic and ongoing colonial practices. The recommendations that will be presented later in this chapter will serve to provide direction for health care providers who provide diabetes care to Aboriginal peoples in a more culturally safe and appropriate manner by taking a more decolonized approach.

Implications for Research and Practice

As I have reached the end of the thesis I have had the opportunity to reflect back on my journey, one that began when I first started the Interdisciplinary PhD in Northern and Rural Health. I recall on a number of occasions being asked the following question, ‘so what’? I remember the first time I was asked it thinking, what does that mean? Now that I have shared my findings, interpretations and provided some conclusions I feel that I am now able to more confidently answer this question.

This is my opportunity to provide the reader with my explanation of the significance of my substantive theory which has demonstrated that Aboriginal peoples living along the North

Shore of Lake Huron clearly revealed to me that their collective experiences of living with diabetes seem to indicate that the historical and ongoing legacies of colonization have impacted them in a number of ways. These include an impact on ways of eating, perceptions about developing diabetes and finally the way in which diabetes health care is delivered by a predominantly Western bio-medical model that is often considered at odds with Aboriginal world views on health and well-being.

The implications for practice include a raised awareness that colonization has an impact on the experience of living with diabetes. A better awareness and understanding of historical and ongoing colonial legacies will assist health care providers in providing diabetes health care services that are decolonized in order to address the numerous health inequities and disparities that confront Aboriginal peoples ultimately contributing to the increased prevalence of type II diabetes amongst this population. The findings from this study suggest that a decolonized model of diabetes care which was presented in the last chapter may contribute to diabetes services that are not only culturally sensitive but also ensure cultural safety. As suggested on a number of occasions it is my contention that since self-determination is a key component of decolonization it is essential that Aboriginal peoples themselves be involved and perhaps even lead the process of determining what a decolonized model of diabetes health care should look like.

Future research should explore the therapeutic benefits of receiving diabetes care that is considered to be decolonized. Strategies for promoting a decolonized model of diabetes care for Aboriginal peoples have not been adequately explored for Aboriginal peoples. Further research is required to better understand what decolonizing approaches might work best when

providing diabetes care to Aboriginal peoples. Lastly, this research is specific to a group of Aboriginal people who live along the North Shore of Lake Huron thus future research should also consider including participants from other geographic areas since their experiences may be different.

Limitations of the study

This study was based on in-depth interviews of twenty Aboriginal participants. Perhaps the most important and obvious limitation of this study is the relative inexperience of the researcher. The use of a constructivist grounded theory approach is a major endeavor that required a variety of skills. Perhaps one of the most important of these is the researcher's ability to conduct interviews that can ultimately capture the complete perspectives his participants. I recognize that as a novice researcher my interviewing skills and abilities were not always readily apparent in some of the earlier interviews however as the study progressed and as a result of conducting subsequent interviews I was able to begin focusing on important core categories that were emerging as my analysis of the data was occurring simultaneously during my data collection. Another possible limitation was that the participants were only interviewed once. It is possible that additional interviews could have assisted in generating data that was more concise or focused.

A possible limitation that has been identified is the fact that only English speaking participants were recruited to participate this study. Individuals who speak little or no English may have shared different experiences. Therefore this limitation in sampling may have led to the generation of only a partial picture of the experience.

Another possible limitation of this study is the small number and heterogeneity of the participants. The participants from this study all resided and had relatively easy access to more populated or urban centres unlike their counterparts who live in remote and isolated First Nations communities in the North. Secondly the age and gender make up of this sample may also limit the extent to which the results could be generalized. As a result the findings of this study cannot be generalized to all Aboriginal populations. That was not the intention of this study. The goal of this research was to perform an in-depth exploration of Aboriginal people's experiences and perceptions about living with type II diabetes in the face of colonization. By using a smaller sample size I was able to explore the participants' experiences in more depth.

Finally, grounded theory studies which are not generalizable are considered to be specific to the population that was studied. That being said it is possible that some of the results from this study could be transferred to fit other similar contexts deemed appropriate by the reader. In this study I have advanced the substantive theory that Aboriginal peoples living with type II diabetes often live with the perception that there is 'no going back' to the way things once were prior to European contact and that as a result they have had to adapt to new ways which can at times be at odds with Aboriginal world views. For many of the participants this adaptation often translates into embracing the best of both worlds when it comes to living with type II diabetes. This adaptation could be viewed as elements that promote a decolonized model of diabetes care for Aboriginal peoples. This substantive theory might be transferrable to other similar contexts.

Recommendations

The major recommendation from this study is that health care providers should aim to provide diabetes health care services to Aboriginal peoples in a culturally safe and decolonized manner. Cultural safety extends beyond awareness, sensitivity and competence and considers awareness of and challenges unequal power relations that seem to exist between many of the participants in this study and their health care providers. This approach might encourage health care providers to take a more critical look at themselves, their culture, their values, their beliefs and how these impact the way in which they relate with Aboriginal peoples in the delivery of diabetes related services.

I believe that an awareness of the historical and ongoing nature of colonization as well as cultural safety can help to expose the social, political, and historical contexts of health care.

This goal could be accomplished in the following ways:

1. Improving the knowledge regarding the historical and ongoing legacies of colonialism for all health care providers who deliver care to Aboriginal peoples. This should be incorporated into all health discipline curricula and might benefit from being delivered utilizing an interdisciplinary approach. An interdisciplinary approach might consist of bringing together health care providers with a variety of experiences from various disciplines. This recommendation was also made in the recent release of the TRC report (TRC, 2015). This approach would not only benefit the novice learner but also the ‘seasoned’ or experienced professionals.
2. Promoting an approach that is not only aware of Aboriginal world views but one that is open to other ways of doing things. This could help us to move away from a primarily

biomedical focus when it comes to diabetes care to one that is more holistic and in keeping with Aboriginal views of health and living in balance by including the social, spiritual and emotional dimensions of Aboriginal peoples into their care. This is certainly not a new or novel approach since to a certain extent is currently happening in Aboriginal communities in which diabetes care and services are offered. Unfortunately these are limited which means that the vast majority of Aboriginal peoples are likely to access their diabetes care from agencies and health care providers who are likely to be less familiar with their culture let alone with the impact of colonization.

3. Encouraging health care providers to take into consideration the role that their personal and professional cultures might play through the use of more practice reflection during their training and once they have entered practice For example as a French Canadian white male I bring to every patient encounter various preconceived values, beliefs and assumptions. Secondly as a Primary Health Care Nurse Practitioner I have been educated and trained within the culture of health care which includes medical and nursing influences. It is these underlying values which have ultimately shaped me into the person that I have become and which need to be considered when I am interacting and working with Aboriginal peoples who have and continue to be marginalized and oppressed as a result of colonial practices and policies. Being sensitive to this reality will better enable health care providers to not only provide culturally safe care but perhaps even develop into a decolonized way of care that might ultimately lead to improved health outcomes for Aboriginal peoples.

4. As it has been previously recommended in the RCAP report and most recently the TRC report of 2015, there should be more Aboriginal health care professionals in the health care system. This recommendation does come with a caution however. Unless there is a renewed focus on the importance of dealing “with cultural and spiritual loss” and “the struggle against political and economic subordination” the addition of Aboriginal health care professionals who are ‘enculturated’ into “a professional culture” such as medicine or nursing will only serve to replicate the current way of doing things with respect to health delivery (Scheder, 2006, 346). We not only need to increase the number of Aboriginal health care providers, we need to ensure that they can help to transform the current professional culture into one that is more culturally safe.
5. Finally but perhaps most importantly planning to return to each of the seven First Nation communities who are represented in this study in order to present the findings and engage community members in a dialogue that will assist in further interpreting the findings and guiding future steps in the development and promotion of a decolonized model of diabetes care for Aboriginal peoples. It is essential that this model be designed in conjunction with Aboriginal peoples themselves who will be the recipients of the care. The model needs to take into consideration the historical and ongoing legacies of colonialism and how these have and continue to impact the diabetes experience in such a way as to create the perception that when it comes to diabetes, Aboriginal peoples should feel that they do have a choice when it comes to their diabetes care and that they should not be expected to simply have to adapt to what currently exists.

I believe that the greatest sources of knowledge from my thesis were ultimately obtained from the participants themselves and that the extensive review of the literature created by other scholars such as myself was secondary. In remaining faithful to the epistemological claims that I made at the outset of my research journey I can now see and appreciate the richness in what the participants shared with me and how their very own words in the end are in fact the evidence of the knowledge that has been created. It is from their own words and through my interpretation and attempts at bringing meaning to what was shared that I hope to be able to influence the way in which type II diabetes care is delivered to Aboriginal peoples.

This study found that the interrelations between and within changing ways of eating, developing diabetes, and choosing your medicine help to explain how Aboriginal peoples often perceive that when it comes to diabetes care they often have few choices available to them and often need to conform or adapt to ways of doing things that might be at odds with some of the cultural values and beliefs. In spite of this the way in which some have elected to combine Traditional and Western ways could assist in promoting a decolonized model of diabetes care. The substantive theory that emerged from the analysis of the data is considered to be dynamic and can help to explain the variations in experiences, conditions, and responses that the participants demonstrated throughout the interviews. In addition it could be argued that this theory helps to provide some explanation of the very complex context bound reality of being an Aboriginal person living with type II diabetes. Furthermore the results from this study seem to suggest that in spite of the historical and ongoing legacies of colonization as well as the dominance of the Western bio-medical approach to diabetes care, considering the combining of Traditional and Western ways could help to promote a more decolonized and culturally

appropriate model of diabetes care. The recommendations that were presented can serve as a guide for action for current and future health care providers alike.

GLOSSARY

There are several terms that are used throughout this thesis. The following text will provide a brief explanation/definition of commonly encountered themes. Some of these were identified as key concepts and have been expanded upon in greater detail in the body of the thesis.

Aboriginal peoples: The descendants of the original inhabitants of North America. The Canadian *Constitution* recognizes three groups of Aboriginal people — Indians, Métis and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs (Government of Canada, 2012).

Anishnaabe: “is the most common term used for group self-identification among Aboriginal people who live around the Great Lakes-Ojibwe/Chippewa, Algongquin/Nippissing, Saulteaux/Missisauga, Odawa, Delaware, Potawatomi and Oji-cree-because of its unique , culture specific meaning as “the First Peoples” (Spielman, 2009 , 11).

Colonization: “Colonization is best conceptualized as an outcome of a multigenerational and multifaceted process of forced dispossession and attempted acculturation-a disconnection from land, culture, and community-that has resulted in political chaos and social discord within First nations communities and the collective dependency of First Nations upon the state” (Alfred, 2009, 52).

Cultural safety: “Involves the recognition of the social, economic and political position of certain groups within society...aims to counter tendencies in health care that create cultural risk...reminds us that it is incumbent on all of us in health care to reflect upon the ways in which our policies, research and practices may recreate traumas inflicted upon Aboriginal people...” (Smye & Browne, 2002: 46-48).

Decolonization: “Decolonization is the process of revealing and dismantling colonialist power in all its forms. This includes dismantling the hidden aspects of those institutional and cultural forces that had maintained the colonialist power and that remain even after political independence is achieved” (Ashcroft, Griffiths, & Tiffin, 2007; 56)

First Nation: A term that came into common usage in the 1970s to replace the word "Indian," which some people found offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Indian peoples in Canada, both Status and non-Status. Some Indian peoples have also adopted the term "First Nation" to replace the word "band" in the name of their community (Government of Canada, 2012).

Interdisciplinary: a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient.

Nurse Practitioner (NP): NPs are Registered Nurses (RNs) in the Extended Class [RN(ECs)] who have additional nursing education and experience. NP competencies build and expand upon RN competencies. NPs have, and demonstrate in practice, the competencies to use their legislated authority to diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform procedures (College of Nurses of Ontario, 2011).

Postcolonial: “deals with the effects of colonization on cultures and societies. As originally used by historians after the Second World War in terms such as the post-colonial state, ‘post-colonial’ had a clearly chronological meaning, designating the post-independence period. However, from the late 1970s the term has been used by literary critics to discuss the various cultural effects from colonization” (Ashcroft, Griffiths, & Tiffin, 2007; 168).

Reserve: Tract of land, the legal title to which is held by the Crown, set apart for the use and benefit of an Indian band (Government of Canada, 2012).

Status Indian: “An individual recognized by the federal government as being registered under the *Indian Act* is referred to as a Registered Indian (commonly referred to as a Status Indian). Status Indians are entitled to a wide range of programs and services offered by federal agencies and provincial governments” (Government of Canada, 2015).

Traditional food: “those that originate from local plant or animal resources through gathering, harvesting, and which possess cultural meaning as a traditional food (Earle, 2011). Sometimes referred to as ‘Indian’ food by some.

Traditional medicine: For the purposes of this thesis this term is very broad and includes the use of certain ‘traditional’ plants or medicines as well as makes reference to the practice of non-Western type medicine by Aboriginal men and women.

Tribal council: A regional group of First Nations members that delivers common services to a group of First Nations (Government of Canada, 2012).

Type II diabetes: Diabetes mellitus is a metabolic disorder characterized by the presence of hyperglycemia due to defective insulin secretion, defective insulin action or both. The chronic hyperglycemia of diabetes is associated with relatively specific long-term microvascular complications affecting the eyes, kidneys and nerves, as well as an increased risk for cardiovascular disease (Canadian Diabetes Association 2013).

REFERENCES

- Adelson, N. (2005). The embodiment of inequity. Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 96(2), 45-61.
- Alfred, T. (1999). *Peace, power, righteousness: An Indigenous manifesto*. Don Mills, Ontario, Canada: Oxford University Press.
- Alfred, T. (2009). Colonialism and state dependency. *Journal of Aboriginal Health*, 5, 42-60.
- Allan, B., & Smylie, J. (2015). First Peoples, second class treatment. The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto: The Wellesley Institute.
- Anderson, J.M. (2004). Lessons from a postcolonial-feminist perspective: Suffering and a path to healing. *Nursing Inquiry*, 11, 239-246.
- Ashcroft, B., Griffiths, G., & Tiffin, H. (2007). *Post-colonial studies: The key concepts* (Second Edition). New York, NY: Routledge, Taylor & Francis Group.
- Assembly of First Nations. (1994). Breaking the silence: An interpretive study of residential school impact and healing as illustrated by stories of First Nations individuals. Ottawa, ON: Native Tribal Health Consortium-Cancer Program.
- Assembly of First Nations (AFN) (2010). AFN environmental stewardship. Respecting and protecting Mother Earth. Traditional Knowledge. Retrieved on January 12, 2015 from: http://www.afn.ca/uploads/files/env/ns_-_traditional_knowledge.pdf
- Baer, H.M., Singer, H., & Johnson, J.H. (1986). Towards a critical medical anthropology. *Social Science and Medicine*, 23, 95-98.

- Bainbridge, R., Whiteside, M., & McCalman, J. (2013). Being, knowing, and doing: A phronetic approach to constructivist grounded theory with Aboriginal Australian partners. *Qualitative Health Research*, 23(2), 275-288.
- Bartlett, J.G., Iwasaki, Y., Gottlieb, B., Hall, D., & Mannell, R. (2007). Framework for Aboriginal-guided decolonizing research involving Métis and First Nations persons with diabetes. *Social Science and Medicine*, 65(2007), 2371-2382.
- Barton, S.S., Anderson, N., & Thommasen, H.V. (2005). The diabetes experience of Aboriginal people living in a rural Canadian community. *Australian Journal of Rural Health*, 13, 242-246.
- Barton, S.S. (2008). Using narrative inquiry to elicit diabetes self-care experience in an Aboriginal population. *Canadian Journal of Nursing Research*, 40(3), 16-36.
- Barton, S.S. (2008). Discovering the literature on Aboriginal diabetes in Canada: A focus on holistic methodologies. *Canadian Journal of Nursing Research*, 40(4), 26-54.
- Battiste, M. (2000). Reclaiming Indigenous Voice and Vision. UBC Press, Vancouver.
- Battiste, M. (2000). Maintaining Aboriginal Identity, language, and culture in modern society. Chapter 15 in: Battiste: Reclaiming Indigenous Voice and Vision. UBC Press, Vancouver.
- Battiste, M. (2008). Research ethics for protecting indigenous knowledge and heritage. In N.K. Denzin, Y.S. Lincoln, & L.T. Smith (Eds). *Handbook of critical and indigenous methodologies*. Pp. 497-509. Sage Publications, Thousand Oaks, California.
- Berry, J.W. (1999). Aboriginal Cultural Identity. *The Canadian Journal of Native Studies* XIX, 1, 1-36.

- Bilge, S. (2009). Théorisation féministes de l'intersectionnalité. *Diogène*, 225, 70-88.
- Bisset, S., Cargo, M., Delormier, T., Macaulay, A., & Potvin, L. (2004). Legitimizing diabetes as a community health issue: A case analysis of an Aboriginal community in Canada. *Health Promotion International*, 19(3), 317-326.
- Blodgett, A.T., Schinke, R.J., Peltier, D., Wabano, M.J., Fisher, L.A., Eys, M.A., Ritchie, S.D., Recollet-Saikkonenb, D., Pheasant, C., & Pickard, P. (2010). 'Naadmaadmi': reflections of Aboriginal community members engaged in sport psychology co-researching activities with mainstream academics. *Qualitative Research in Sport and Exercise*, 2(1), 56-76.
- Bodirsky, M. (2000). Decolonizing diet: healing by reclaiming traditional foodways. *The Journal of Canadian Food Cultures* 1(1), 1-11.
- Bombay, A, Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health*, (November), 6-47.
- Boston, P., Jordan, S., MacNamara, E., Kozolanka, K., Bobbish-Rondeau, E., Iserhoff, H., et al. (1997). Using participatory action research to understand the meanings Aboriginal Canadians attribute to the rising incidence of diabetes. *Chronic Diseases in Canada*, 18, 5-12.
- Borovoy, A., & Hine, J., (2008). Managing the unmanageable: Elderly Russian Jewish émigrés and the biomedical culture in diabetes care. *Medical Anthropology Quarterly*, 22(10), 1-26.

- Bowling, A. (2009). *Research Methods in Health. Investigating Health and Health Services*. 3rd Ed. Open University Press, U.K.
- Brant-Castellano, M., (2004). Ethics of Aboriginal Research. *Journal of Aboriginal Health, January*, 98-114.
- Breckenridge, J.P., Jones, D., Elliot, I., & Nicol, I. (2012). Choosing a methodological path: Reflections on the constructivist turn. *Grounded Theory Review, 11*(1), 1-10.
- Brooks, S., & Miljan, L. (2003). *Public Policy in Canada. An Introduction*. Fourth Edition. Oxford: University Press.
- Brown, L., & Strega, S. (Ed.). (2005). *Research as Resistance: Critical Indigenous, & anti-oppressive approaches*. Toronto: Canadian Scholars' Press.
- Browne, A.J., Smye, V.L., & Varcoe, C. (2005). The Relevance of Postcolonial Theoretical Perspectives to Research in Aboriginal Health. *Clinical Journal of Nursing Research, 37* (4), 16-37.
- Browne, A.J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M.J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy, 2009* (10), 167-179.
- Bruyere, J., & Garro, L.C. (2000). He travels in the body: nehinaw (Cree) understandings of diabetes. *The Canadian Nurse, 96* (6), 25-28.
- Burke, J. A., Earley, M., Dixon, L. D., Wilke, A., & Puczynski, S. (2006). Patients with Diabetes Speak: Exploring the Implications of Patients' Perspectives for Their Diabetes Appointments. *Health Communication, 103*-114.

- Byrne, C., & Nkongolo, K.K. (2011). Genetic susceptibility for type 2 diabetes mellitus among North American Aborigines. *International Journal of Medicine and Medical Sciences*, 40(10), 220-231.
- Campbell, G. (1989). The changing dimension of Native American health: A critical understanding of contemporary Native American health issues. *American Indian Culture and Research Journal* 13(4), 1-20.
- Canadian Diabetes Association (2013). Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. *Canadian Journal of Diabetes*, 37(1), S1-S212.
- Canadian Diabetes Association (2013). Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. *Canadian Journal of Diabetes*, 37, S1-S227.
- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanity Research Council of Canada. (2005). Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans.
- Canadian Institutes of Health Research. (2013). CIHR Team in Aboriginal Anti-diabetic Medicines. Available from: <http://www.taam-emaad.umontreal.ca/>. Retrieved 05/01/2015.
- Canadian Institute for health information. Improving the health of Canadians. Summary. Aboriginal peoples health. Retrieved August 5th 2010 from: <http://secure.cihi.ca.cihiweb/disPage.jsp?cw-page=media-25feb2004-b3-e>.

- Canadian Institutes of Health Research. (2007). CIHR Guidelines for Health Research Involving Aboriginal People.
- Cargo, M., Levesque, L., Macaulay, A., McComber, A., Desrosiers, S., Delormier, T., et al. (2003). Community governance of the Kahnawake Schools Diabetes Prevention Project, Kahnawake territory, Mohawk Nation, Canada. *Health Promotion International*, 18(3), 177-187.
- Cargo, M., Person, L., Levesque, L., & Macaulay, A. (2007). Perceived wholistic health and physical activity in Kanien`Keha: ka youth. *Pimatisiwin: A Journal of Indigenous and Aboriginal Community Health*, 5(1), 87-109.
- Cargo, M., Delormier, T., Levesque, L., Horn-Miller, K., McComber, A., & Macaulay, A.C. (2008). Can the democratic ideal of participatory research be achieved? An inside look at an academic-indigenous community partnership. *Health Education Research*, 23(5), 904-914.
- Charmaz, K. (2006). Constructing Grounded Theory: A practical guide through qualitative analysis. Sage Publications, Los Angeles.
- Charmaz, K. (2009). Shifting grounds: Constructivist grounded theory methods. Chapter 6 in: Developing Grounded Theory: The Second Generation. Morse et al. (eds). Left Coast Press Inc., Walnut Creek, California.
- Chaufan, C., & Weitz, R. (2009). The elephant in the room: the invisibility of poverty in research on type 2 diabetes. *Humanity & Society*, 33, 74-98.

- Cochran, P., Marshall, C., Garcia-Downing, C., Kendall, E., Cook, D., McCubbin, L., & Gover, R. (2008). Indigenous ways of knowing: implications for participatory research and community. *Health Policy & Ethics*, 98(1), 22-27.
- Collier, J. (1905). The Theory of Colonization. *American Journal of Sociology*, 11(2), 252-265.
- Corbin, J., & Strauss, A. (2008). Basics of qualitative research. Third Edition. Sage Publications, Los Angeles.
- Cornthassel, J. (2012). Re-envisioning resurgence: Indigenous pathways to decolonization and sustainable self-determination. *Decolonization: Indigeneity, Education & Society*. 1 (1), 86-101.
- Cote-Meek, S. (2010). Exploring the impact of ongoing colonial violence on aboriginal students in the postsecondary classroom. Doctoral dissertation. Available at: <https://tspace.library.utoronto.ca/handle/1807/24729>
- Creswell, J.W. (2003). Research Design. Qualitative, Quantitative, and Mixed Methods Approaches. 2nd Ed. Sage Publications, Thousand Oaks.
- Creswell, J.W. (2007). Qualitative Inquiry & Research Design. Choosing among five approaches. 2nd Ed. Sage Publications, Thousand Oaks.
- Czyzewski, K. (2011). Colonialism as a broader social determinant of health. *The International Indigenous Policy Journal*, 2(1), 1-16.
- Daniel, M., & Green, L. (1995). Application of the Precede-Proceed Planning Model in diabetes prevention and control: A case illustration from a Canadian Aboriginal community. *Diabetes Spectrum*, 8, 74-84.

- Delormier, T., Cargo, M., Kirby, R., McComber, A., Rice, J., & Potvin, L. (2003). Activity implementation as a reflection of living in balance: The Kahnawake Schools Diabetes Prevention Project. *Pimatisiwin: A Journal of Indigenous and Aboriginal Community Health*, 1(1), 45-163.
- Dickason, O. (1992). Aboriginal history of Canada's First Nations: A history of founding peoples from earlier times. Toronto: McClelland and Stewart.
- Dorlin, E. (2008). Sexe, Genre et sexualités. Paris: Presses Universitaires de France.
- Dorlin, E. (2009). Sexe, Race, Classe, pour une épistémologie de la domination. Paris: Presses Universitaires de France.
- Dumont, J. (2005). First Nations Regional Longitudinal Health Survey (RHS). Cultural Framework. 1-16.
- Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany, NY: State University of New York Press.
- Durie, M. (2004). Understanding health and illness: research at the interface between science and indigenous knowledge. *International Journal of Epidemiology*, 33(5), 1138-1143.
- Dyck, R., Osgood, N., Lin, T.H., Gao, A., & Stang, M.R. (2010). Epidemiology of diabetes mellitus among First Nations and non-First Nations adults. *Canadian Medical Association Journal*, 182(3), 249-260.
- Dyson, S., & Brown, B. (2006). Social theory and applied health research. New York, NY: Open University Press.

- Earle, L. (2011). Traditional Aboriginal diets and health. National Collaborating Centre for Aboriginal Health. Retrieved from: http://www.nccah-ccnsa.ca/docs/social%20determinates/1828_NCCAH_mini_diets_health_final.pdf
- Emberley, J.V. (2009). Defamiliarizing the Aboriginal. Cultural practices and decolonization in Canada. University of Toronto Press, Toronto.
- Fanon, F. (1952). Black skin, white masks. New York, Grove Press.
- Farmer, P. (2005). Pathologies of Power. Health, human rights, and the new war on the poor. University of California Press, Berkeley.
- Ferreira, M.L., & Lang, G.C. (2006). Indigenous peoples and diabetes. Community empowerment and wellness. Carolina Academic Press, Durham, North-Carolina.
- Fisher, P.A., & Ball, T.J. (2003). Tribal participatory research: Mechanisms of a collaborative model. *American Journal of Community Psychology*, 32(3-4), 207-216.
- First Nations and Inuit Regional Health Survey (FNIRHS) National Committee (2005). First Nations, Regional Longitudinal Health Survey (RHS) 2002/03. Results for Adults, Youths, and Children living in First Nation Communities. Ottawa: FNIRHS National Committee.
- First Nations Centre. (2005). First Nations regional longitudinal health survey (RHS) 2002/2003: Results for Adults, youth and children living in First Nations communities. Ottawa. First Nations Centre at the National Aboriginal Health Organization.
- Flanagan, T. (2012). First Nations? Second thoughts. McGill-Queen's University Press: Montreal & Kingston.

- Flicker, S., & Travers, R., Guta, A., McDonald, S., & Meagher, A. (2007). Ethical dilemmas in community-based participatory research. Recommendations for institutional review boards. *Journal of Urban Health*, 84(4), 478-493
- Foucault, M. (1963). *The Birth of the Clinic*. Paris: Presses Universitaires de France.
- Frideres, J.S. & Gadacz, R.R. (2008). *Aboriginal Peoples in Canada*. 8th Ed. Prentice Hall, Toronto.
- Frohlich, K.L., Ross, N., & Richmond, C. (2006). Health disparities in Canada today: Some evidence and a theoretical framework. *Health Policy*, 79, 132-143.
- Furniss, E. (1999). *The burden of history: Colonialism and the frontier myth in a rural Canadian community*. Vancouver: University of British Columbia Press.
- Gahagan, S., & Silverstein, J. (2003). Prevention and treatment of type 2 diabetes mellitus in children, with special emphasis on American Indian and Alaska Native children. *Pediatrics* 112(4), 328-347.
- Gandhi, L. (1998). *Postcolonial theory: A critical introduction*. New York: Columbia University Press.
- Garcia-Smith, D. (1994). The Gila River Diabetes Prevention Model. Chapter 17 in Joe & Young (Eds.) *Diabetes as a Disease of Civilization: The impact of Culture Change on Indigenous Peoples*, pp. 471-493. Mouton de Gruyter, New York.
- Garro, L.C. (1995). Individual or societal responsibility: Explanations of diabetes in an Anishinaabe (Ojibway) community. *Culture, Medicine and Psychiatry*, 40, 37-46.
- Gilbert, Helen; Tompkins, Joanne (1996). *Post-Colonial Drama: Theory, Practice, Politics*. London: Routledge.

- Giles, B.G., Findlay, C.S., Haas, G., LaFrance, B., Laughing, W., & Pembleton, S. (2007). Integrating conventional science and aboriginal perspectives on diabetes using fuzzy cognitive maps. *Social Science & Medicine*, 64(3), 562-576.
- Gittelsohn, J., Harris, S.B., Burns, K.L., Kakegamic, L., Landman, L.T., Sharma, A., et al. (1996). Use of ethnographic methods for applied research on diabetes among the Ojibway-Cree community in northern Ontario. *Health Education Quarterly*, 23(3), 365-382.
- Glaser, B.G. (1978). Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley CA: Sociology Press.
- Glaser, B.G. (2005). The grounded theory perspective III: Theoretical coding. Mill Valley CA: Sociology Press.
- Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. New York: Simon and Schuster Inc.
- Golden, S.H. (2007). A review of the evidence for a neuroendocrine link between stress, depression and diabetes mellitus. *Current Diabetes Reviews*, 3, 252-259.
- Government of Canada. (2012). Aboriginal Affairs and Indian and Northern Development Canada. Indian Status. Retrieved from: <https://www.aadnc-aandc.gc.ca/eng/1100100032374/1100100032378>
- Government of Ontario (2006). Ontario Aboriginal Diabetes Strategy. 1-40.
- Grix, J. (2002). Introducing students to the generic terminology of social research. *Politics*, 22, 175-186.

- Hall, S. (1996). When was the post-colonial? Thinking at the limit. In I Chambers & L. Curti (Eds.). *The postcolonial question: Common skies, divided horizons*. pp 242-260. London, Routledge.
- Hagey, R. (1984). The phenomenon, the explanations and the responses: Metaphors surrounding diabetes in urban Canadian Indians. *Social Science & Medicine*, 18, 265-272.
- Hanley, A.J.G., Harris, S.B., Barnie, A., Gittlesohn, J., Wolever, T.M., Logan, A., et al. (1995). The Sandy Lake Health and Diabetes Project: Design, methods and lessons learned. *Chronic Diseases in Canada*, 16(4), 149-156.
- Hanley AJ, Harris SB, Mamakeesick M, Goodwin K Fiddler E, Hegele RA, et al. Complications of Type 2 Diabetes Among Aboriginal Canadians: prevalence and associated risk factors. *Diabetes Care* 2005;28(8): 2054–2057.
- Harjo, S. (2005). My New Year's Resolution: No more fat "Indian" food. *Indian Country Today*. <http://indiancountrytodaymedianetwork.com/2005/01/26/my-new-years-resolution-no-more-fat-indian-food-94439>. Retrieved April 2, 2015..
- Harris, S.B., Ekoe, JM, Zdanowicz, Y. & Webster-Bogaert, S. (2005). Glycemic control and morbidity in the Canadian primary care setting (results of the diabetes in Canada evaluation study). *Diabetes Research and Clinical Practice*, 70, 90-97.
- Hart, M.A. (2002). *Seeking Mino-Pimatisiwin. An Aboriginal approach to helping*. Fernwood Publishing, Halifax.

- Health Canada. (2000). Diabetes among Aboriginal people in Canada: The Evidence.
http://www.hc-sc.gc.ca/fnih-spnia/alt_formats/fnihb-dgspni/pdf/pubs/diabete/2001_evidence_faits-eng.pdf
- Hegele, R.A. (2001). Genes, environment and diabetes in Canadian Aboriginal communities. *Advances in Experimental Medical Biology*, 498, 11-20.
- Heintze, H.J. (1993). The protection of Indigenous Peoples under the ILO Convention. In Amazonia and Siberia: Legal aspects of the preservation of the environment and development in the last open spaces. London: Graham & Trotman.
- Helman, C.G. (2000). Culture, health and illness. Fourth Edition. Oxford University Press, New York.
- Herbert, C. (1996). Community-based research as a tool for empowerment: The HaidaGwaii Diabetes Project example. *Canadian Journal of Public Health*, 87, 109-112.
- Hernandez, C.A., Antone, I., & Cornelius, I. (1999). A grounded theory study of the experience of type 2 diabetes in First Nations adults in Canada. *Journal of Transcultural Nursing*, 10, 220-228.
- Hingangaroa-Smith, G. (2000). Protecting and Respecting Indigenous Knowledge. Chapter 16, pp 209-224 in: Reclaiming Indigenous Voice and Vision. Toronto, UBC Press.
- Huber, M., Knottnerus, A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., Leonard, B., ...Smid, H. (2011). How should we define health. *British Medical Journal*, 343, 4163-4176.

- Hutchinson, S.A., & Wilson, J.S. (2001). Grounded theory: The method. In P.L. Munhall, Nursing Research: A qualitative perspective (3rd Ed.). Jones & Bartlett Publishers: Sudbury, MA.
- Hux, J.E., & Tang, M. (2002). Diabetes in Ontario, Practice Atlas, Chapter 1. Patterns of prevalence and incidence of diabetes. http://www.ices.on.ca/file/DM_Chapter1.pdf
- Idle no More. (2015). Retrieved from: <http://www.idlenomore.ca/>.
- Illich, I. (1995). Limits to medicine. Medical nemesis: The expropriation of health. Marion Boyars, New York.
- Indian Residential School Survivors Society. (2006). History, <http://www.irsss.ca/history.html>
- International Diabetes Federation (IDF) (2010). Diabetes Atlas: Prevalence estimates of diabetes mellitus (DM). Available from: <http://www.diabetesatlas.org/>.
- Iwasaki, Y., Bartlett, J., & O'Neil, J. (2004). An examination of stress among Aboriginal men and women with diabetes in Manitoba, Canada. *Ethnicity and Health*, 9(2), 189-212.
- Jabareen, Y. (2009). Building a Conceptual Framework: Philosophy, Definitions, and Procedures. *International Journal of Qualitative methods*, 8(4), 49-62.
- Jacklin, K. & Kinoshameg, P. (2008). Developing a Participatory Aboriginal Health Research Project: "Only if it's going to mean something." *Journal of Empirical Research of Human Research Ethics* 3(2):53-68.
- Jacklin, Kristen (2009) Diversity Within: Deconstructing Aboriginal Health. *Social Science and Medicine* Volume 68 (5), Pages 980-989.
- Jacklin, K. & Warry, W. (2012). Decolonizing First Nations Health in Kulig & Williams: Health in Rural Canada. UBC Press, Vancouver.

- Jenness, D. (1977). *The Indians of Canada*. Toronto: University of Toronto Press.
- Joe, J.R., & Young, R.S. (1994). *Diabetes as a disease of civilization. The impact of culture change on indigenous peoples*. Mouton de Gruyter, New York.
- Kaspar, V. (2014). The lifetime effect of Residential School attendance on Indigenous health status. *Journal of Public Health, 104*(11), 2184-2190.
- Kawachi, I., Subramanian, S.V., & Kim, D. (Ed.) (2008). *Social Capital and Health*. Boston, MA; Springer.
- Kelm, Mary-Ellen (1998). *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*. Vancouver: UBC Press.
- Kelm, Mary-Ellen (2004). Wilp W a'ums: colonial encounter, decolonization and medical care among the Nisga'a. *Social Science and Medicine, 59*, 335-339.
- Kenny, C. (2004). A holistic framework for Aboriginal policy research. Funded by Status of Women Canada's Policy Research Fund. 1-65.
- King-Hooper, B., Schulz, C., & Watts, J. (1995). A First Nations community-based diabetes education programme: The Nuu-Chah-Hulth experience. In S. MacDonald, K. Anderson, & S. Roe-Finlay (Eds.), *Diabetes and indigenous peoples: Theory, reality, hope (pp. 91-95)*. Winnipeg: Assembly of First Nations.
- Kirby, A., Levesque, L., Wabano, V., & Robertson-Wilson, J. (2007). Perceived community environment and physical activity involvement in a northern-rural Aboriginal community. *International Journal of Behavioural Nutrition and Physical Activity, 4*(63), 1-8.

- Kirmayer, L., Bass, G., & Tait, C. (2000). The mental health of Aboriginal peoples: Transformation of identity and community. *Canadian Journal of Psychiatry* 45:607-615.
- Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing & the Human Condition*. USA: Basic Books.
- Kelm, M.E. (1998). *Colonizing bodies. Aboriginal health and healing in British Columbia 1900-50*. UBC Press, Vancouver.
- Koch, T., & Kralik, D. (2006). *Participatory Action Research in Health Care*. Blackwell Publishing, Oxford, UK.
- Kohler-Riessman, C. (2008). *Narrative Methods for the Human Sciences*. Thousand Oaks, CA: Sage Publications.
- Kuhn, T.S. (1996). *The Structure of the Scientific Revolutions (Third Edition)*. Chicago: The University of Chicago Press.
- Kuhnlein, H.V. (1992). Change in the use of traditional foods by the Nuxalk native people of British Columbia. *Ecology of Food and Nutrition*, 27, 259-282.
- Kuhnlein, H.V. & Receveur, O. (1996). Dietary change and traditional food systems of Indigenous peoples. *Annual Reviews of Nutrition*, 16: 417-442.
- Kurtz, D.L.M., Nyberg, J.C, Van Den Tilaart, S, & Mills, B. (2008). Silencing of voice: an act of structural violence. Urban Aboriginal women speak out about their experiences with health care. *J Aboriginal Health* 1:53-63, 2008.
- Laenui, P. (2000). *Process of decolonization in: Reclaiming Indigenous Voice and Vision*. Chapter 11 pp. 150-159.

- Lang, G. C., (1989). "Making sense" about diabetes: Dakota narratives of illness. *Medical Anthropology*, 11,305-327.
- Lemchuk-Favel, L., & Jock, J.G. (2004). Aboriginal health systems in Canada : nine case studies. *Journal of Aborginal Health*, 1(1), 6-24.
- Lawrence, B. (2004). Real Indians and others: Mixed-blood urban native peoples and Indigenous nationhood. British Columbia, Canada: University of British Columbia Press.
- Levesque, L., Cargo, M., &Salsberg, J. (2004).Development of the Physical Activity Interactive Recall (PAIR) for Aboriginal children.*International Journal of Behavioral Nutrition and Physical Activity*, 1(8), 1-8.
- Levesque, L., Guilbault, G., Delormier, T., & Potvin, L. (2005). Unpacking the black box: A deconstruction of the programming approach and physical activity interventions implemented in the Kahnawake Schools Diabetes Prevention Project. *Health Promotion Practice*, 6(1), 64-71.
- Liamputtong, P. (2010). Performing Qualitative Cross-Cultural Research. Cambridge University Press, New York.
- Liaw, S.T., Lau, P., Pyett, P., Furler, J., Burchill, M., Rowley, K., & Kelaheer, M. (2011). Successful chronic disease care for Aboriginal Australians requires cultural competence. *Australian and New Zealand Journal of Public Health*, 35(3), 238-248.
- Lightfoot, N., Strasser, R., Maar, M. &Jacklin, K. (2008).Challenges and rewards of health research in northern, rural, and remote communities.*Annals of Epidemiology*, 18(6), 507-514.

- Little Bear, L. (2000). Jagged worldviews colliding. Chapter 5 in: Battiste, Reclaiming Indigenous Voice and Vision. UBC Press, Vancouver.
- Loomba, A. (2005). Colonialism/Postcolonialism (2nd Edition). New York, NY: Routledge, Taylor & Francis Group.
- Liu, J., Young, T., Zinman, B., Harris, S.B., Connelly, P.W., & Hanley, A.J.G. (2006). Lifestyle variables, non-traditional cardiovascular risk factors, and the metabolic syndrome in an Aboriginal Canadian population. *Obesity*, 14(3), 500-508.
- Lustman, P.J. & Clouse, R.E. (2007). Depression in diabetes: The chicken or the egg? *Psychosomatic Medicine*, 69, 297-299.
- McPerson, C. (2012). A rights-based approach to primary health care. Increasing accountability for health inequities with health systems strengthening. In McGibbon (Eds), Oppression: A social determinant of Health (pp 150-166). Halifax: Fernwood Publishing.
- Maar, M., Gzik, D., & Larose, T. (2010). Beyond Expectations: Why Do Aboriginal and Euro-Canadian Patients with Type 2 Diabetes on a Northern, Rural Island Demonstrate Better Outcomes for Glycemic, Blood Pressure and Lipid Management than Comparison Populations? *Canadian Journal of Diabetes* 34(2), 127-135.
- Maar, M., & Shawande, M. (2010). Traditional Anishinabe healing in a clinical setting: the development of an Aboriginal interdisciplinary approach to community-based aboriginal mental health care. *Journal of Aboriginal Health*, January, 18-27.
- Maar, M.A., Lightfoot, N.E., Sutherland, M.E., Strasser, R.P., Wilson, K.J., Lidstone-Jones, C.M., Graham, D.G., Beaudin, R., Daybutch, G.A., Dokis, B.R., Lesage, M.T.,

- Raymond, M., & Williamsom, P. (2011). Thinking outside the box: Aboriginal people's suggestions for conducting health studies with Aboriginal communities. *Public Health*, 125, 747-753.
- Maar, M., Manitowabi, D., Gzik, D., McGregor, L., & Corbiere, C. (2011). Serious complications for patients, care providers and policy makers: tackling structural violence of First Nations People living with Diabetes in Canada. *The International Indigenous Policy Journal*, 2(1), 1-16.
- Maar, M. (2004)** Clearing the Path for Community Health Empowerment: Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario. *Journal of Aboriginal Health* 1, 54-64.
- Mamaweswen. (2010). The North Shore Tribal Council: Annual report. pp. 1-60.
- Mandel, E., and Chapman, G.E. (2010). A decolonizing approach to health promotion in Canada: the case of the Urban Aboriginal Community Kitchen Garden Project. *Health Promotion International*, 25(2), 166-173.
- Manitowabi, D., & Shawande, M. (2011). The meaning of Anishinabe healing and wellbeing on Manitoulin Island. *Pimatisiwin: A journal of Aboriginal and Indigenous Community Health*, 9(2), 441-458.
- Manitowabi, D., & Maar, M. (2013). Coping with colonization. Aboriginal diabetes on Manitouland Island in Indigenous bodies: Reviewing, Relocating, Reclaiming. Edited by Fear-Segal, J., & Tillett, R. Albany: State University of New York Press.
- Marchildon, G.P. (2006). Health Systems in Transition: Canada. Toronto: University of Toronto Press.

- Martin, K. & Mirraboopa, B. (2003) 'Ways of knowing, being and doing: A theoretical framework and methods for indigenous and indigenist re-search', *Journal of Australian Studies*, 27: 76, 203-214.
- Mashford-Pringle, A. (2011). How'd we get here from there? American Indians and Aboriginal Peoples of Canada health policy. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 9(1), 153-175.
- Mathews, J. (1996). Aboriginal Health: Historical, Social and Cultural Influences, in *Aboriginal Health: Social and Cultural Transitions*, G. Robinson (Ed), NTU Press, Darwin, pp. 29-38.
- Maxwell, J. A. (2006). *Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: Sage
- McCall, L. (2005). The complexity of intersectionality. *Journal of Women in Culture and Society*, 30(3), 1771-1800.
- McConaghy, C. (2000). Rethinking Indigenous education: Culturalism, colonialism, and the politics of knowing. Brisbane, Post Pressed.
- McMullin, J. (2010). Understanding social inequality. Intersections of class, age, gender, ethnicity, and race in Canada. Second Edition. Oxford University Press.
- McComber, A., Macaulay, A., Kirby, R., Desrosiers, S., Cross, E., & Saad-Haddad, C. (1996). The Kahnawake Schools Diabetes Prevention Project: Community Participation in a diabetes primary prevention research project. *International Journal of Circumpolar Health*, 96, 370-374.

- Mead, A. (2002). Six differences between Aboriginal and Western world views. Retrieved January 11, 2015 from:
<http://www.donpugh.com/Psych%20Interests/ABORIGINES/SIX%20DIFFERENCES%20BETWEEN%20ABORIGINAL%20and%20%60WESTERN'%20WORLD%20VIEW%20EWS-.pdf>
- Memmi, A. (1965). *The colonizer and the colonized* (Expanded Edition). Boston: Beacon Press.
- Memmi, A. (2000). *Racism*. Minneapolis: University of Minnesota Press. Memmi, A. (2006). *Decolonization and the decolonized*. Minneapolis: University of Minnesota Press.
- Mignone, J. (2009). Social Capital and Aboriginal communities: A critical assessment. Synthesis and assessment of the body of knowledge on social capital with emphasis on Aboriginal communities. *Journal of Aboriginal Health, November*, 100-147.
- Milburn, M. (2004). Indigenous Nutrition: using traditional food knowledge to solve contemporary health problems. *American Indian Quarterly*, 28(3), 411-434.
- Miles, M.B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source book* (2nd ed.). Newbury Par, CA: Sage.
- Mills, J. & Birk, M. (2014). *Qualitative methodology: A practical guide*. Los Angeles, CA: Sage
- Minkler, M., & Wallerstein, N. (2008). *Community-Based Participatory Research for Health: From Process to Outcomes*. 2nd Edition. John Wiley & Sons, United States of America

- Montour, L. (2000). The medicine wheel: Understanding “problem” patients in primary care. *The Permanente Journal*, 4(1). Retrieved from: www.thepermanentejournal.org/files/Winter2000/wheel.pdf.
- Moore, H.D., Kruse, F.F., Tisdall, & Corrigan, S.C. (1946). Medical survey of nutrition among the Northern Manitoba Indians. *Canadian Medical Association Journal*, 54(1946), 223-233.
- Morrison, N., & Dooley, J. (1996). The Sioux Lookout Diabetes Program: Diabetes prevention and management in northwestern Ontario. *International Journal of Circumpolar Health*, 96, 364-369.
- Morse, J.M., & Richards, L. (2002). *Readme First for a User’s Guide to Qualitative Methods*. Thousand Oaks, CA: Sage Publications.
- Morse, J.M., Noerager-Stern, P., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A.E. (2009). *Developing Grounded Theory. The Second Generation*. Left Coast Press Inc., Walnut Creek, California.
- Mosby, I. (2013). Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942–1952. *Social History*, 46(91), 145-172.
- Nabigon, H., Hagey, R., Webster, S., & MacKay, R. (1999). The learning circle as research method: the trickster and Windigo in Research. *Native Social Work Journal* 2 (1), 113-137.

- National Aboriginal Health Organization (NAHO). (2007). OCAP: Ownership, Control, Access and Possession. Sanctioned by the First Nations Information Governance Committee. ISBN: 978-0-9780785-8-4
- National Collaborating Centres for Aboriginal Health. (2009). Aboriginal health: A patchwork of policies and legislation. Retrieved from: <http://www.nccah-ccnsa.ca/252/aboriginal-health-a-patchwork-of-policies-and-legislation.nccah>
- National Collaborating Centre for Aboriginal Health (2010). Culture and language as social determinants of First Nation, Inuit and Metis health. Retrieved from: http://www.nccah.ca/docs/fact%20sheets/social%20determinates/NCCAH_fs_culture_1_language_EN.pdf
- Natural Resources Canada (1996). The Atlas of Canada. Retrieved January 14, 2011 from: <http://atlas.nrcan.gc.ca/site/english/maps/peopleandsociety/lang/aboginallanguages>.
- Neel, J.V. (1962). Diabetes mellitus: a thrifty genotype rendered detrimental by progress? *American Journal of Human Genetics*, 14, 353-362.
- Neel, J.V. (1999). The thrifty genotype in 1998. *Nutrition Reviews*, 57, S2-S9.
- Norris, M.J. (1998). Aboriginal languages in Canada: Emerging trends and perspectives on second language acquisition. *Statistics Canada. Canadian Social Trends*, 51, 19-27.
- O'Neil, J. (1986). The politics of health in the Fourth World: A Northern Canadian Example. *Human Organization*, 45(2), 119-128.
- Organista, P., Marin, G., & Chun, K.M. (2010). Acculturation, Chapter 4 in: The psychology of ethnic groups in the United States. Sage Publications, Inc. pp.99-133.

- Paillé, P. (1994). L'analyse par théorisation ancrée. *Cahiers de recherche sociologique*, 23, 147-181.
- Pirraglia, P.A. & Gupta, S. (2007). The interaction of depression and diabetes: A review. *Current Diabetes Reviews*, 3, 249-251.
- Pierre, N., Receveur, O., Macaulay, A., & Montour, L. (2007). Identification of barriers and facilitators of healthy food choices among children aged 6 to 12 years: from the Kanawake Schools Diabetes Prevention Project. *Ecology of Food and Nutrition*, 46(2), 101-123.
- Pilkington, F.B., Daiski, I, Bryant, T., Dinca-Panaitescu, M., Dinca-Panaitescu, S, & Raphael, D. (2010). The experience of living with diabetes for low-income Canadians. *Canadian Journal of Diabetes*, 34(2), 119-126.
- Pilkington, F.B., Daiski, I, Lines, E., Bryant, T., Raphael, D., Dinca-Panaitescu, M., & Dinca-Panaitescu, S, (2011). Type 2 Diabetes in Vulnerable Populations: Community Healthcare Providers' Perspectives on Health Service Needs and Policy Implications. *Canadian Journal of Diabetes*, 35(5), 503-511.
- Pilon, R. (2008). Understanding the Experience of Living with Type 2 Diabetes from the Perspective of the Older Adult. Unpublished Master's thesis. Sudbury, Canada: Laurentian University Press.
- Poonwassie, A. , & Charter, A. (2001). An Aboriginal worldview of helping: Empowering approaches. *Canadian Journal of Counselling*, 35(1), 63-73.
- Potvin, L., Cargo, M., McComber, A., Delormier, T., & Macaulay, A. (2003). Implementing participatory intervention and research in communities: Lessons from the Kahnawake

- Schools Diabetes Prevention Project in Canada. *Social Science and Medicine*, 56, 1295-1305.
- Poudrier, J. (2007). The geneticization of Aboriginal diabetes and obesity: adding another scene to the story of the Thrifty Gene. *CRSA*, 44(2), 237-261.
- Power, E.M. (2008). Conceptualizing Food Security for Aboriginal People in Canada. *Canadian Journal of Public Health*, March-April, 95-97.
- Prior, D. (2007). Decolonizing research: a shift toward reconciliation. *Nursing Inquiry* 14(2), 162-168.
- Public Health Agency of Canada. (2011). Diabetes in Canada: Facts and Figures from a public health perspective. Chapter 6-Diabetes among First Nations, Inuit, and Metis populations. Retrieved from: <http://www.phac-aspc.gc.ca/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/chap6-eng.php>
- Ramsden, I. (1992). Teaching cultural safety. *New Zealand Nursing Journal*, 85(1), 21-23.
- Ramsden, I. (1993). Kawa Whakaruruhau. Cultural safety in nursing education in Aotearoa (New Zealand). *Nursing Praxis in New Zealand*, 8(3), 4-10.
- Ramsden, I. (2000). Cultural safety/ Kawa Whakaruruhau ten years on: a personal overview. *Nursing Praxis in New Zealand*, 15(1), 4-12.
- Raphael, D. (2007). Poverty and Policy in Canada: Implications for health and quality of life. Toronto: Canadian's Scholars' Press Inc.
- Raphael, D. (2009). Social Determinants of Health (Second Edition). Toronto: Canadian's Scholars' Press Inc.

- Reading J. (2009). The crisis of chronic disease among Aboriginal peoples: A challenge for public health, population health and social policy. Victoria. Centre for Aboriginal health research/University of Victoria.
- Reading, C.L., & Wien, F. (2009). Health Inequalities and Social Determinants of Aboriginal Peoples' Health. National Collaborating Centre for Aboriginal Health. 1-41.
- Rigney, L.I. (1999). Internationalization of an Indigenous Anticolonial Cultural Critique of Research Methodologies: A Guide to Indigenous Research Methodology and Its Principles. *WicazoSa Review*, 14(2), 109-121.
- Robbins, J.A., & Dewar, J. (2011). Traditional Indigenous approaches to healing and the modern welfare of Traditional Knowledge, spirituality, and lands. A critical reflection on practices and policies taken from the Canadian Indigenous example. *The International Indigenous Policy Journal*, 2(4), 1-17.
- Rock, M. (2003). Sweet blood and social suffering: rethinking cause-effect relationships in diabetes, distress, and duress. *Medical Anthropology*, 22, 131-174.
- Rolfe, G. (2004). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Methodological Issues in Nursing Research*, 304-310.
- Ross, R. (2014). Indigenous Healing. Exploring traditional paths. Toronto, Penguin Canada Books Inc.
- Royal Commission on Aboriginal Peoples (1996). *Final Report of the Royal Commission on Aboriginal Peoples*. Ottawa: RCAP.
- Said, E.W. (1993). Culture and Imperialism. New York: Random House, Inc.

- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.
- Scheder, J.C. (2006). Emotion, grief, and power: reconsideration of Hawaiian Health. Chapter 1, pp 33-52. In Ferreira & Lang Eds. *Indigenous peoples and diabetes. Community empowerment and wellness*. Carolina Academic Press, Durham, North-Carolina.
- Schinke, R.J., Hanrahan, S.J., Eys, M.A., Blodgett, A., Peltier, D., Ritchie, S.D., Pheasant, C., & Enosse, L. (2008). The Development of Cross-Cultural Relations with a Canadian Aboriginal Community through Sport Research. *Quest*, 60, 357-369.
- Schwandt, T.A. (2001). *Dictionary of Qualitative Inquiry (Second Edition)*. Thousand Oaks, CA: Sage Publications.
- Seca, J.M. (2010). *Les représentations sociales*. 2^e Éditions. Armand Colin Éditeur, Paris.
- Shah, C. P. (2005). Health status report of Aboriginal people in Ontario. Funded and supported by the Ontario Ministry of Health and Long Term Care.
- Sherifali, D., Shea, N., & Brooks, S. (2012). Exploring the experiences of urban first nations people living with or caring for someone with type 2 diabetes. *Canadian Journal of Diabetes*, 36(2012), 175-180.
- Sherwood, J., & Edwards, T. (2006). Decolonisation: a critical step for improving Aboriginal health. *Contemporary Nurse*, 22(2), 178-190.
- Shohat, E. (1992). Note on the "Post-colonial". *Social Text*, 31/32, 99-113.
- Shroff, F.M. (2011). Power politics and the takeover of holistic health in North America: An exploratory historical analysis. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 9(1), 129-152.

- Shubair, M.M., & Tobin, P.K. (2010). Type 2 diabetes in First Nations populations: a case example of clinical practice guidelines. *Rural and Remote Health*, 101505, 1-7.
- Sikolia, D., Biros, D., Mason, M., & Weiser, M. (2013). Trustworthiness of Grounded Theory Methodology Research in Information Systems. *Association for Information Systems. Proceedings of the Eight Midwest Association for Information Systems Conference, Normal Illinois. May 24-25, 2013. 1-5.*
- Sinclair, R. (2003). Indigenous research in social work: The challenge of operationalizing worldview. *Native Social Work Journal*, 5, 117-139.
- Smye, V., & Browne, A. (2002). Cultural safety and the analysis of health policy affecting Aboriginal people. *Nurse Researcher*, 9(3), 42-56.
- Skye, A.D. (2010). Aboriginal midwifery: A model for change. *J Aboriginal Health* 1:28- 37.
- Smith, L.T. (1999). *Decolonizing Methodologies. Research and Indigenous Peoples.* University of Otago Press, Dunedin.
- Smith, D., Edwards, N., Martens, P.J., Varcoe, C., & Davies, B. (2008). The Influence of governance n organizations' experiences of improving care for Aboriginal people: decolonizing possibilities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 6(1), 3-28.
- Smye, V., & Browne, A. (2002). Cultural safety and the analysis of health policy affecting aboriginal people. *Nurse Researcher*, 9(3), 42-56.
- Smylie, J., & Anderson, M. (2006). Understanding the health of Indigenous peoples in Canada: key methodological and conceptual challenges. *CMAJ*, 175(6), 602-605)

- Socha, T., Zahaf, M., Chambers, L., Abraham, R., & Fiddler, T. (2012). Food security in a Northern First Nations Community: An exploratory study on food availability and accessibility. *Journal of Aboriginal Health*, 8(2), 5-14.
- Spielmann, R. (2002). You're so fat! Exploring Ojibwa discourse. University of Toronto Press.
- Spielmann, R. (2009). Anishnaabe World: A survival guide for building bridges between Canada and First Nations. Your Scrivener Press, Sudbury, Ontario.
- Statistics Canada (2001). Censuses of Population.
- Statistics Canada (2006). Community profiles from the 2006 Census.
- Statistics Canada. (2011). National Household Survey. Analytical document.
- Aboriginal Peoples in Canada: First Nations People, Métis and Inuit. Retrieved January 18, 2011 from: <http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm>
- Streiner, D. L., & Norman, G.R. (2008). Health Measurement Scales : A practical guide to their development and use (Fourth Edition). New York, NY: Oxford University Press Inc.
- Struthers, R., Schanche-Hodge, F., Geishirt-Cantrell, B., & DeCora, L. (2003). Participant experiences of talking circles on type 2 diabetes in two Northern Plains American Indian Tribes. *Qualitative Health Research*, 13(8), 1094-1115.
- Sugars, C. (2004). Unhomely states: Theorizing English-Canadian Postcolonialism. Peterborough, Ontario: Broadview Press.
- Suls, J., & Wallston, K.A. (2003). Social Psychological Foundations of Health and Illness. Malden, MA: Blackwell Publishing.

- Sunday, J., Eyles, J., & Upshur, R. (2001). Applying Aristotle's doctrine of causation to Aboriginal and biomedical understandings of diabetes. *Culture, Medicine and Psychiatry*, 25(63), 63-85.
- Syme, S. (2004). Social determinants of health: the community as an empowered partner. Preventing chronic disease [serial online], I(I): 1-5.
http://www.cdc.gov/pcd/issues/2004/jan/pdf/03_0001.pdf.
- Thorne, S. (2008). Interpretive Description. Walnut Creek, CA: Left Coast Press Inc.
- Travers, K.D. (1995). Using qualitative research to understand the sociocultural origins of diabetes among Cape Breton Mi'kmaq. *Chronic Diseases in Canada*, 16, 140-143.
- Trigger, B.G. (1985). Natives and Newcomers. Canada's "Heroic Age" reconsidered. Montreal: McGill-Queen's University Press.
- Truth and Reconciliation Commission of Canada (TRC). (2012). Interim Report. Retrieved from:
<http://www.myrobust.com/websites/trcinstitution/File/Interim%20report%20English%20electronic.pdf>
- Truth and Reconciliation Commission of Canada (TRC). (2015). Honouring the Truth, Reconciling for the Future. Summary of the Final Report of the Truth and Reconciliation Commission of Canada. Retrieved from:
http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Exec_Summary_2015_05_31_web_o.pdf

- Turner, N.J., & Turner, K.L. (2008). "Where our women used to get the food": cumulative effects and loss of ethnobotanical knowledge and practice; case study from coastal British Columbia. *Botany*, 86, 103-115.
- Turton, C.L. (1997). Ways of knowing about health: An Aboriginal perspective. *Advances in Nursing Science*, 19(3), 28-36.
- United Nations. (1983). United Nations Economic and Social Council's Sub-Commission on the Prevention of Discrimination and Protection of Minorities. Working group on Indigenous populations. Retrieved from: http://www.ciesin.org/docs/010-000/Indigenous_Pop.html March 12, 2014.
- Varcoe, C., & Dick, S. (2008). The Intersecting Risks of violence and HIV for rural Aboriginal women in a Neo-Colonial Canadian context. *Journal of Aboriginal Health* 1:42-52.
- Waldram, J.B., Herring, D.A., & Young, T.K. (2007). Aboriginal Health in Canada. Historical, Cultural, and Epidemiological Perspectives. 2nd Ed. University of Toronto Press, Toronto.
- Waldram, J.B. (2009). Culture and Aboriginality in the study of mental health. Chapter 3, pp.56-79 in: *Healing traditions: The Mental health of Aboriginal Peoples in Canada*. Toronto, UBC Press.
- Warry, W. (1998). *Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government*. University of Toronto Press Incorporated, Toronto.
- Warry, W. (2007). *Ending Denial: Understanding Aboriginal issues*. University of Toronto Press, Toronto, Canada.

- Waziyatawin-Wilson, A., & Yellow Bird, M. (2005). *For Indigenous eyes only. A decolonization handbook*. School of American Research Press, Santa Fe.
- Waziyatawin & Yellow Bird, M. (2012). *For Indigenous minds only. A decolonization handbook*. School for Advanced Advanced Research Press, Santa Fe.
- Weatherford, J. (1988). *Indian Givers: How the Indians of the Americas Transformed the World*. New York: Crown Publishers Inc.
- Weaver, S. (1990). A new paradigm in Canadian Indian policy for the 1990s. *Canadian Ethnic Studies*, 22(3).
- Wesley-Esquimaux, C. C., & Smolewski, M. (2004). *Historic trauma and Aboriginal healing*. Ottawa, Ontario, Canada: Aboriginal Healing Foundation.
- White, K. (2002). *An Introduction to the Sociology of Health and Illness*. Thousand Oaks, CA: Sage Publications.
- Widdowson, F., & Howard, A. (2000). *Disrobing the Aboriginal industry. The deception behind Indigenous cultural preservation*. Montreal: McGill-Queens University Press.
- Wiedman, D. (2006). Striving for healthy lifestyles: contributions of anthropologists to the challenge of diabetes in Indigenous communities. Chapter 20, pp 511-534. In Ferreira & Lang Eds. *Indigenous peoples and diabetes. Community empowerment and wellness*. Carolina Academic Press, Durham, North-Carolina.
- Williams, G., & Wood, P. (1986). Common sense beliefs about illness: a mediating role for the doctor. *The Lancet*, 27, 1435-1437.

- Wilson, A. C. (2005). Reclaiming our humanity. Decolonization and the Recovery of Indigenous Knowledge. Chapter 18. Pp. 255-263. In *War and Border Crossings: Ethics when cultures clash*. Maryland, Rowman & Littlefield Publishers Inc.
- Wilson, A.M., Magarey, A.M., Jones, M., O'Donnell, K., & Kelly, J. (2015). Attitudes and characteristics of health professionals working in Aboriginal health. *The International Electronic Journal of Rural and Remote Health, Research, Education, Practice & Policy*, 15(2739), 1-11.
- Wilson, K., & Young, T.K. (2008). An overview of Aboriginal health research in the social sciences: current trends and future directions. *International Journal of Circumpolar Health*, 67(2-3), 179-189.
- Wilson, K., & Rosenberg, M.W., & Abonyi, S. (2010). Aboriginal peoples, health and healing approaches: The effects of age and place on health. *Social Science & Medicine*, 72, 355-364.
- Wilson, S. (2008). *Research is Ceremony: Indigenous Research Methods*. Fernwood Publishing, Winnipeg, Manitoba.
- Wolcott, H.F. (2009). *Writing up Qualitative Research* (3rd Edition). Thousand Oaks, CA: Sage Publications.
- World Health Organization. (1948). WHO definition of health. Retrieved on January 22, 2015 from: <http://www.who.int/about/definition/en/print.html>
- Young, T., Reading, J., Elias, B., O'Neil, J.D. (2000). Type 2 diabetes mellitus in Canada's First Nations: status of an epidemic in progress. *Canadian Medical Association Journal*, 163(5), 561-566.

- Young, R.J.C. (2001). *Postcolonialism: An historical introduction*. Oxford, Blackwell.
- Young, R.J.C. (2003). *Postcolonialism: A very short introduction*. New York: Oxford University Press.
- Young, T., & Bruce, S.G. (2003). Defining, understanding and controlling the diabetes epidemic in Canada's Aboriginal population: seeking solutions through interdisciplinary research. *Canadian Journal of Diabetes*, 27(4), 439-441.
- Yu, C.H., & Zinman, B. (2007). Type 2 diabetes and impaired glucose tolerance in aboriginal populations: A global perspective. *Diabetes Research and Clinical Practice*, 78, 159-170.
- Zawilski, V., & Levine-Rasky, C. (2005). *Inequality in Canada. A reader on the intersections of gender, race, and class*. Oxford University Press, Don Mills, Ontario.
- Zavala, M. (2013). What do we mean by decolonizing research strategies: Lessons from decolonizing, Indigenous research projects in New Zealand and Latin America. *Indigeniety, Education & Society*, 2(1), 55-71.

APPENDIX A:



"Working Together"

M * Whitefish Lake First Nation
A * Sagamok Anishnawbek
M *
A * Serpent River First Nation
W * Mississauga First Nation
E *
S * Thessalon First Nation
W * Garden River First Nation
E * Batchewana First Nation
N *

The North Shore Tribal Council

HEAD OFFICE:
 P.O. Box 28
 Hwy. 17 East
 Cutler, Ontario
 P0P 1B0

Tel: (705) 844-2340
 Fax: (705) 844-2563

HEALTH PROGRAM:
 Tel: (705) 844-2021
 Fax: (705) 844-2844

BRANCH OFFICE
 P.O. Box 2049
 1 Industrial Park Rd., E.
 Blind River, Ontario
 P0R 1B0

Tel: (705) 356-1691
 Fax: (705) 356-1090

March 30, 2011

Roger Pilon- PhD Student
 School of Rural and Northern Health
 Interdisciplinary PhD in Rural and Northern Health
 935 Ramsey Lake Road
 Sudbury, ON P3E 2C6

Subject: Request to conduct the following study: "Type 2 diabetes as a manifestation of colonization: What do Aboriginal people living along the North Shore of Lake Huron think?"

Dear Mr. Pilon,

It was a pleasure to be able to meet with you in person this past December in Sault Ste Marie and more recently in Cutler. The presentations that you provided to our Board of Directors and our health steering committee regarding your proposed research project were very informative and well received. We have since reviewed a copy of your formal research proposal. On behalf of the North Shore Anishnawbek Health Steering Committee I would like to inform you that your request to conduct your proposed research study in the seven First Nation communities along the North Shore of Lake Huron has been approved by our Health Directors. The next step is to prepare a brief overview of your research objectives and methodology, as well as a description of how this will benefit their community. Each First Nation Health Director will then take this information directly to their individual Chief and Council for approval.

It is expected that you will undergo the ethics review process of the Laurentian University Research Ethics Board. When that process has been completed and you have received approval, we will expect to receive a copy of the letter of approval for our records. Once we receive notification of your ethics approval you can proceed in making the necessary arrangements with our Diabetes Nurse Educator to initiate the process of participant recruitment.

We would like to wish you well as you embark upon this research journey and partnership with our First Nation communities. We look forward to participating in this process and sharing in the new knowledge that will be discovered. It is anticipated that the findings of this research can be used to influence policy and ultimately translate into improved diabetes health services for our people.

Sincerely,

Gloria Daybutch

cc. NSAHSC-Health Directors

APPENDIX B

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS
Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL	New	X	Modifications to project	Time extension
Name of Principal Investigator and school/department	Roger Pilon (Nursing – LU); Monique Benoit Ph.D. (supervisor)			
Title of Project	<i>Type 2 diabetes as a manifestation of colonization: What do Aboriginal people living along the North Shore of Lake Huron think?</i>			
REB file number	2011-04-12			
Date of original approval of project	July 11 th 2011			
Date of approval of project modifications or extension (if applicable)				
Final/Interim report due on	July 11 th 2012			
Conditions placed on project	Final or Interim report on July 11 th 2012			

During the course of your research, no deviations or changes to the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please complete the appropriate [REB form](#).

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate [REB FORM](#).

In all cases, please ensure that your research complies with the [Tri-Council Policy Statement \(TCPS\)](#). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations, and best of luck in conducting your research.



Jean Dragon Ph.D. for Susan James Ph.D.
Acting Chair of the *Laurentian University Research Ethics Board*
Laurentian University

APPENDIX C



FORM FOR ANNUAL REPORT, REPORT COMPLETION, AND REQUEST FOR CHANGES TO A PROJECT for research projects involving human participants

File #	2011-04-12
Title of Project	Type 2 diabetes as a manifestation of colonization: What do Aboriginal people living along the North Shore of Lake Huron think?
Principal Investigator and Supervisor (if applicable)	Roger Pilon (Nursing-LU)/Monique Benoit PhD (supervisor)
Is this a multi-year project? (Yes/No)	
Date of original ethics approval	July 11 th 2011
Date project completed (if applicable)	
For incomplete projects, tentative date of completion of project.	April 2013
For incomplete projects, date of next report (no more than 1 year after this report)	
Date This Report Submitted	October 31, 2011

- “Completed” means having terminated all contact with potential or actual participants for the purposes of the project, except for final feedback of the project’s results.

SECTION A – NOTICE OF COMPLETION OF PROJECT

1	How many subjects participated in the project?	
2	Were some subjects removed from the study? • How many, and for what principal reason?	
3	Did some subjects leave the study after they agreed to participate? • How many, and for what principal reason?	
4	Specific issues or problems that arose (e.g., difficulty in recruiting, unexpected or serious events, ambiguities, etc) and how you handled them.	
5	How are you ensuring data security during storage?	

SECTION B – REQUESTING TIME EXTENSIONS OR CHANGES TO A PROJECT

	<i>Briefly describe the changes proposed. Please re-submit your full revised project to REB for evaluation, highlighting any changes in a different colour, and attach any new letters/forms that have been changed.</i>	
6	• Time extension	
7	• Recruitment methods or types of participants	My original proposal outlined that individuals >50 years of age who have had type 2 diabetes for at least 5 years would be recruited for this study. Upon further review and consideration of the literature with respect to type 2 diabetes in Aboriginal peoples I would like to remove the limitation of >50 years of age and state recruitment will target adults over the age of 18 who have had type 2 diabetes for approximately 5 years (CDA, 2008). By broadening my inclusion criteria I lessen the possibility of excluding participants who may have a lot to contribute but who would otherwise have been excluded. I foresee no impact on potential risks for participants by broadening my recruitment age and in fact could argue that there could be more benefit by not excluding potential participants.
8	• Procedures	
9	• Forms: letters, consent etc.	
10	• Other changes not listed above	

Signature of Principal Investigator	Date
Roger Pilon-original with signature to follow Revised September 2010	October 31, 2011

APPENDIX D



Laurentian University
Université Laurentienne

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL	New	Modifications to project	X	Time extension
Name of Principal Investigator and school/department	Roger Pilon (Nursing – LU); Monique Benoit Ph.D. (supervisor)			
Title of Project	<i>Type 2 diabetes as a manifestation of colonization: What do Aboriginal people living along the North Shore of Lake Huron think?</i>			
REB file number	2011-04-12 R1			
Date of original approval of project	July 11 th 2011			
Date of approval of project modifications or extension (if applicable)	October 31 st 2011 (R1)			
Final/Interim report due on	October 31 st 2012			
Conditions placed on project	Final or Interim report on October 31 st 2012			

During the course of your research, no deviations or changes to the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please complete the appropriate [REB form](#).

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate [REB FORM](#).

In all cases, please ensure that your research complies with the [Tri-Council Policy Statement \(TCPS\)](#). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations, and best of luck in conducting your research.

Jean Dragon Ph.D. for Susan James Ph.D.
Acting Chair of the Laurentian University Research Ethics Board
Laurentian University

APPENDIX E (INFORMATION FOR PARTICIPANTS)



Information and Consent for Prospective Participants

Study Title: *Type 2 diabetes as a manifestation of colonization: What do Aboriginal people living along the North Shore of Lake Huron think?*

Institution: Laurentian University-School of Rural and Northern Health

Investigator: Roger Pilon- NP-PHC, MScN (principal investigator)
Monique Benoit PhD (Thesis Supervisor)

Background

Prior to 1940, there was very little diabetes in Aboriginal people. An increase in the number of Aboriginal people with type 2 diabetes appeared to occur after the Second World War. In fact it seems that Aboriginal peoples develop type 2 diabetes 3 to 5 times more often than non-Aboriginal people. . Diabetes has reached “epidemic proportions among Aboriginal peoples in Canada. There have been no studies conducted on type 2 diabetes in the North Shore Tribal Council area.

Purpose

This study is being done to better understand how Aboriginal people live with type 2 diabetes. It is also hoped that we will be able to understand how colonization may have impacted type 2 diabetes in Aboriginal people. Colonization is defined as the outcome of white domination and control over Aboriginal peoples.

Description of Research

If you volunteer for this study, you will be asked to participate in an interview which will last approximately one to two hours. During the interview you will be asked to describe what it is

like to live with type 2 diabetes.

The interview will be recorded and typed out into words.

Potential Risks

There are no known risks associated with this study. The interviews will be conducted by a nurse experienced in the care of individuals living with type 2 diabetes.

If you become too fatigued or upset at any time, the interview will be terminated. If you want to continue the interview it can be rescheduled at another time that might be more convenient for you. You will be provided with the opportunity to withdraw from the study at any time without any fear that the care or the services you have been receiving will be affected.

Benefits

You will be given \$20.00 for participating in this study. It is also anticipated that the information gathered from this study may assist health care providers to improve their care and services.

Confidentiality

The Principal Investigator will be responsible for making sure that all the information you provide and share remains confidential. You have the right to privacy and you are free to either disclose or not disclose information. Your consent form and interview recordings will eventually be destroyed after about seven years' time. No information that could possibly identify you will be released, share or published. If you require further information regarding confidentiality please ask the principal investigator.

If you decide to participate in the study, your name will not appear anywhere in the information collected about you. The results of this study may be published, but, your name will not be used and there will be no way to link you with the study through any other information.

Participant Rights

Your participation in this study is voluntary. If you agree to participate, you are under no obligation to answer any of the questions if you are uncomfortable sharing the information. In addition, you are free to change your mind about being involved in this project at any time. If you have any questions or concerns regarding this research study you can contact:

Roger Pilon- Principal Investigator (705) 918-6586 or (705) 675-1151 (ext. 3733) or

Toll free: 1-800-461-4030 ext: 3733 (rpilon@laurentian.ca).

Monique Benoit PhD- Thesis Supervisor, Laurentian University, (705) 675 1151.

APPENDIX F: (CONSENT FORM)

CONSENT

I acknowledge that the research procedures described above have been explained to me and that all questions that I have asked have been answered to my satisfaction. I know that I can ask questions at any time. I have been informed of my right not to participate in this study and of my right to withdraw at any time without compromising the medical care that I receive. The potential harms and inconveniences have been explained to me, and I also understand the benefits of participating in the research study. I have been assured that records relating to me will be kept confidential and that no information will be released or printed that would disclose my personal identity without my permission, unless required by law. I will receive a signed copy of this consent form.

The Laurentian University Ethics Board has reviewed this study. If you have any questions about this research, please contact Dr. Jean Dragon, jdragon@laurentian.ca, Laurentian University Research Office, Ramsey Lake Road, Sudbury, ON, Canada P3E 2C6 or telephone toll free: 1-800-461-4030 ext 3213.

By signing this form I have not given up any of my legal rights that I would otherwise have as a research participant.

I would like to participate in this study.

_____	_____
Name of Participant (please print)	Signature of Participant

Date

I confirm that I have explained the nature and effect of this study to the person who signed the above consent form.

_____	_____
Name of person soliciting consent	Signature of person soliciting consent

Date

Participant #: _____

Honorarium (\$20.00):

☐ Accepted- Signature: _____

☐ Declined

APPENDIX G : PARTICIPANT DEMOGRAPHICS

PARTICIPANT DEMOGRAPHICS

Participant	Gender	Age	Year of Diagnosis	# years with diabetes	Education level	Occupation	Treatment
1	F	45	1998	13	College	Admin	Insulin
2	F	65	1994	17	Elementary	Retired	Medication
3	F	66	1999	12	Secondary	Retired	Insulin
4	M	61	1991	20	Secondary	Self-employed	Insulin
5	M	56	2006	5	Secondary	Self-employed	Medication
6	F	60	1997	14	Secondary	Self-employed	Insulin
7	F	61	1997	14	Secondary	Self-employed	Insulin
8	M	61	1995	16	Secondary	Disability	Medication
9	M	56	1990	21	Secondary	Disability	Medication
10	M	78	1998	13	Elementary	Retired	Insulin
11	F	55	2002	10	College	Health care	Medication
12	F	61	2005	7	University	Retired	Insulin
13	F	64	1982	20	Secondary	Homemaker	Insulin
14	M	46	1983	29	Secondary	Laborer	Insulin
15	F	53	2004	8	Secondary	Disability	Medication
16	M	70	1990	22	Elementary	Retired	Medication
17	F	72	1997	15	Secondary	Retired	Insulin
18	M	62	1982	30	Secondary	Retired	Insulin
19	F	68	2004	8	University	Retired	Medication
20	F	59	1985	27	Secondary	Retired	Insulin
21	M	63	1992	20	College	Retired	Medication
22	F	60	1982	30	Elementary	Retired	Insulin
N=22	F=13 M=9	Avg: 61		17.4 years			Medication= 9 Insulin=13

APPENDIX H (INTERVIEW GUIDE)

INTERVIEW GUIDE BY THEME

1. CULTURE

- What does culture mean or represent for you?
- What does being an Aboriginal person mean to you?
- How important is your culture? Why?
- What influence has your culture (that is, being a First Nation person or Anishnawbek) had on your experience with type 2 diabetes?
- Colonization: examples of or experience with:
 - racism,
 - discrimination,
 - oppression,
 - marginalization,
 - sexism

2. DIABETES/HEALTH

- What does being healthy mean to you?
- What does type 2 diabetes mean to you?
- Can you remember how you felt when you first found out you had diabetes?

3. RELATIONSHIP WITH HCPS/HEALTH CARE SYSTEM/TRADITIONAL HEALERS

- How would you describe your experience with the health care system as it relates to your diabetes?
- How would you describe your relationship with your HCPs?
- What role do traditional healers, beliefs or practices play in the management of your health?

APPENDIX I (DEMOGRAPHIC DATA)

DEMOGRAPHIC DATA/INFORMATION

Interview #:_____ Date: _____ Time: _____ Location: _____

1. Name:

2. Telephone:

3. Age:

4. Gender:

☐ Male

☐ female

5. Marital status:

6. Any children and or dependents:

☐ YES

☐ NO

7. Current home town:

☐ Rural

☐ Urban

☐ Northern

8. Current level of education:

☐ Elementary

☐ Secondary (high school)

☐ College

☐ University

9. Occupation: ☐ YES

☐ NO if no how long have you been unemployed

10. Date of diagnosis with type 2 diabetes:

YEAR:

11. Primary health care provider:

☐ NSTC

☐ Traditional Healer

☐ Other:

12. Current treatment for diabetes:

☐ Diet

☐ Oral medication(s)

☐ Insulin

13. Diabetes related complications:

☐ Vision

- ☐ Kidneys
- ☐ Circulation
- ☐ Heart
- ☐ Other

14. Family history of type 2 diabetes

- ☐ YES if yes who:
- ☐ NO

As a token of my appreciation for your time and the sharing of your experience of living with type 2 diabetes, please accept this small gift. (\$20.00: accepted ☐ declined ☐).

Chi miigwetch! (Thank you)

APPENDIX J : SAMPLE INTERVIEW SUMMARY

Interview synthesis/overview

Participant #: 4
 Age: 61
 # years living with diabetes: 20
 Treatment: INSULIN
 Education level: Secondary
 Occupation: Self-employed

